Health and Community Services

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

25TH JULY 2024

Government of Jersey

Health and Community Services

AGENDA

MEETING: Part A - Health and Community Services Advisory Board
DATE: Thursday 25th July 2024
TIME: 9:30am – 12:30pm
VENUE: Main Hall, St Paul's Centre, Dumaresq Street, St Helier, Jersey JE2 3RL

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

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

	Agenda Item	Purpose	Presenter	Time
1	**Welcome and Apologies (including quoracy)**	For **Information**	Chair	**9:30pm**
2	**Declarations of Interest**	For **Information**	Chair	
3	**Minutes of the Previous Meeting** *Paper*	For **Decision**	Chair	
4	**Matters Arising and Action Tracker** *Tracker*	For **Decision**	Chair	
5	**Chair's Introduction** *Verbal*	For **Information**	Chair	**9:35am**
6	**Chief Officer's Report** *Paper*	For **Information**	Chief Officer	**9:40am**
7	**Public Health**	For **Discussion**	Director of Public Health	**09:50am**
8	**Update on the implementation of 'A Palliative and End of Life Care Strategy for Adults in Jersey'**	For **Information**	Associate Director of Improvement and	**10:10am**

	Paper		Innovation, Palliative Care Consultant	
9	**Patient Charter** *Paper*	For **Approval**	Chief Nurse	**10:20am**
10	**Outcomes of the Ward Based Peer Reviews** *Paper*	For **Assurance**	Chief Nurse	**10:30am**
11	**Health and Safety Q1 2024 Report** *Paper*	For **Assurance**	Health and Safety Manager	**10:35am**
	Comfort Break			**10:45am**
12	**Royal College of Radiology Report including a Review of Mammography Service** *Paper*	For **Assurance**	Medical Director	**10:50am**
13	**Rheumatology Update** *Paper – To follow*	For **Assurance**	Medical Director	**11:00am**
14	**Medicine Improvement Plan** *Paper*	For **Assurance**	Medical Director	**11:10am**
15	**2024 HCS Annual Plan - Q2 Progress Report** *Paper*	For **Assurance**	Associate Director of Improvement and Innovation	**11:15am**
16	**2025 Annual Business Planning Approach** *Paper*	For **Approval**	Associate Director of Improvement and Innovation	**11:20am**
17	**Quality and Performance Report Month 6** *Paper*	For **Assurance**	All Executive Directors	**11:25am**
18	**Dermatology Sustainability** *Paper*	For **Information**	Head of Access	**11:35am**
19	**Finance Report Month 6** *Paper*	For **Assurance**	Interim Lead of Finance Business Partnering HCS	**11:40am**
20	**Proposed Future Workforce Report Structure** *Paper*	For **Information**	Director of Workforce	**11:55am**
21	**Committee Reports**: - People and Culture - Finance and Performance - Quality, Safety and Improvement *Paper*	For **Assurance**	Committee Chair	**12 Noon**
22	**Board Assurance Framework** *Paper*	For **Assurance**	Chief Officer	**12:15pm**
QUESTIONS FROM THE PUBLIC (Relating to Agenda Items Only)				
	Questions		Chair	
	MEETING CLOSE Date of next meeting: **26th September 2024**			**12:30pm**

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

Health and Community Services

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

Voting Members:		
Carolyn Downs CB - **CHAIR**	Non-Executive Director	**CD**
Dame Clare Gerada DBE	Non-Executive Director	**CG**
Anthony Hunter OBE	Non-Executive Director	**AH**
Julie Garbutt	Non-Executive Director	**JG**
Chris Bown	Chief Officer HCS	**CB**
Dr Adrian Noon	Chief of Service – Medicine, deputising for Patrick Armstrong MBE, Medical Director	**AN**
Obi Hasan	Finance Lead – HCS Change Team (TEAMS)	**OH**
Non-Voting:		
Jessie Marshall	Chief Nurse	**JM**
Andy Weir	Director of Mental Health Services, Adult Social care and Intermediate Services	**AW**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Emily Hoban	Head of Access, deputising for Claire Thompson, Chief Operating Officer – Acute Services	**EH**
Dr Cheryl Power	Director of Culture, Engagement and Wellbeing	**CP**
Cathy Stone	Nursing / Midwifery Lead – HCS Change Team (TEAMS)	**CS**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**
David Goosey	Chair of the Safeguarding Partnership Board (Item 8 only)	**DG**
Alison Renouf	Safeguarding Partnership Board Manager (Item 8 only)	**AR**
Roslyn Bullen Bell	Director of Midwifery (Item 14 only)	**RBB**

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

CD welcomed all in attendance. This will be the last monthly meeting and the meetings will take place bimonthly hereafter. The next meeting will be at the end of July 2024.

Meeting is quorate.

Apologies received from:

Mr Patrick Armstrong MBE	Medical Director	**PA**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**

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

No declarations.

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

The minutes of the previous meeting held on 28 March 2024 were agreed as accurate.

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

The actions were acknowledged as either being addressed through today's agenda or a future agenda.

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

As above.

6	Board Assurance Framework	Action
• CB advised that the Government of Jersey (GOJ) Risk Team welcomed the development of the Board Assurance Framework (BAF) and provided positive feedback. • The BAF is included at the beginning of each senior leadership team meeting to ensure focus on risk as each agenda item is discussed. • In addition, the BAF is discussed at the end of each meeting to determine whether any agenda items have a material impact on the BAF. • EOC echoed CB's points in that the BAF must now embed as part of the business-as-usual risk management process. CD concluded that the areas assessed as high risk in the BAF are all covered on today's agenda.		

7	Chief Officer's Report	Action
CB took the paper as read and reminded the Board that this report is a summary of the key issues HCS faced during April and touches on some issues from May. In addition: - Ian Tegerdine, the newly appointed Director of Workforce will be attending the Board meeting in July 2024. - During a visit to both Sandybrook and the Hollies Day Centre, CB was very impressed with the motivation of staff and care delivered to service-users. - CB thanked those involved in the opening of the refurbished maternity unit. - A report will be provided to the Board (likely July 2024) on the outcome of the review of those patients who died whilst under care of rheumatology services, including any referrals to the Viscount. - Unfortunately, the Workforce report does not include accurate data, particularly regarding vacancies and sickness absence (noted after the report was circulated). This will be rectified, and a report recirculated to the Board and uploaded to the website. - HCS continues to face significant financial pressures with a risk of at least £18m in the year-end forecast. Possible mitigations have been shared with the Ministerial team, but these will not be implemented due to the impact on clinical services. The future of healthcare funding will need to be progressed politically. CD thanked CB and invited questions, highlighting that questions can be asked by any member of the Board (not just the Non-Executive Directors (NEDs)). CG asked how the recruitment gaps are being addressed in Mental Health Services. AW clarified that there are currently 92 vacancies in MHS, of these 17 posts have been offered. Psychiatrists are continually being recruited and following a series of interviews over recent months, two psychiatrists and three middle grade doctors have been recruited. Key to this is a focussed MH recruitment campaign and AW working with an advertising agency to explore this; it needs to be about getting people interested in the idea of working in MHS in Jersey and matching people's skills with what is available. In addition, looking at developing staff internally and two staff are being sponsored this year to undertake nursing training (this supports staff who want to develop and are unable to afford to stop working to do this training). This initiative is also being explored for psychology training. CG thanked AW and noted the reassurance that recruitment in MHS is being managed. CD asked what percentage of people on the ADHD waiting list are then diagnosed with ADHD (to give an idea about the accuracy of referrals). AW responded that an initial screen takes place and the conversion rate for a diagnostic assessment is > 90%. The service clinician would say this is because those who are unlikely to receive an ADHD diagnosis are redirected following the initial screening. However, as the waiting list is so large, it needs to be reviewed in its entirety, thinking about prioritisation and to ensure that those on the list should still be on the list. A senior specialist nurse has been employed for two days per week to review this list. The current position remains that demand hugely outstrips clinical capacity. CD asked if the ADHD waiting list will ever reach a normalised position and if so when. AW responded that currently there is no clear path to reach a normal run-rate without significantly increasing diagnostic capacity. This is very different from the waiting list for dementia assessment services where a piece of work has been done with the clinical team that has led to a trajectory of achieving a 6-week referral to		

diagnosis by the end of 2024. There is no clear plan regarding ADHD as simply there is not the diagnostic capacity. The Board recognised this is an International problem and in some places in the UK, services have had to close to new referrals.

Regarding young people who have not had a confirmed diagnosis, CD asked what happens to their educational and health and care plan. AW responded that the waiting list in Children Services is very different and is currently under one year. Childrens mental health activity regarding neurodiversity has increased greatly and accounts for the vast majority of CAMHS activity; this is very different from five years ago. Reassuringly, most children are being seen within a reasonable timeframe.

8	**Safeguarding**	**Action**

DG and AR joined the meeting by TEAMS for this item.

AW and JM presented a series of slides (addendum to these minutes) to provide the Board with an understanding of the current safeguarding arrangements in HCS and how these relate to the Safeguarding Partnership Board (SPB).

CD thanked DG for attending the meeting and asked the Board to note that DG has been the Chair of the SPB for only a month. Recognising that safeguarding is an element of the Jersey Care Commission (JCC) inspection, CD asked DG for his first impressions, particularly regarding what could be differently, what could be improved and / or what do we need to do more of. Key points,

- DG been in post since Feb 2024 and the post is a 27 day per year role.
- Appointed as the Chair of the SPB and to act as an independent scrutineer (the latter being a departure from the predecessor). The Independent Scrutineer is a fairly well-developed process in the context of safeguarding children and to some extent, adult safeguarding, acting as a critical friend to the system providing support and challenge to member agencies that make up the partnership. Over time, it is envisaged that the role will change to have more of an emphasis on this role (rather than the Chair role). Anticipating that the independent oversight and scrutiny will be helpful to present at future Board meetings.
- Initial observations (stressing these are just observations) include an underdeveloped statutory framework for safeguarding adults.
- The vast majority of the effort of the SPB needs to be placed in multi-agency, multi-professional communication.
- The role of the SPB could be split into two primary functions. Firstly, the coordination of safeguarding activity (children and adults) across the system and secondly, holding agencies to account for their contributions to this system. Initial observations are that neither of these functions are developed sufficiently.
- There is an Accountable Officer (AO) group for the safeguarding of children and HCS is represented. It was decided at the last meeting that there should be a similar group for adult safeguarding. This needs to be a strategic oversight group, setting the key direction of travel for safeguarding on the Island. The meeting frequency has been reduced from 6 times a year to 4 times a year.
- Data: the SPB has two subcommittees which deal with quality assurance for children and adults. Whilst there is some data available from member agencies, it is fair to say that the quality of the data needs to be improved to understand how the system works for those needing a safeguarding service.
- The SPB is a large Board and may need to be reduced to include only the key agencies that have the main responsibility for safeguarding and to focus on the key task of coordinating and holding to account.
- The system in Jersey is complex and requires streamlining to focus on safeguarding the needs of vulnerable children and adults.

CD thanked DG and noted that safeguarding as a remit of the Board is dealt with by the Quality, Safety and Improvement Committee chaired by Dame Clare Gerada DBE and Tony Hunter CBE (Non-Executive Lead for Safeguarding).

Noting the emphasis on partnership and holding to account, AH reflected this very much echoes from his experience. Three key points,

1. This is a complex, critical high-profile area.
2. Alignment of policy and practice. A question for every Board member is how we can be confident that the policies in practice are consistently implemented.
3. What is the learning? Is there a culture of sharing and learning whereby the safeguarding priority can developed in forward looking ways.

CG expressed concern at the number of safeguarding referrals and the emotional toll these can have on healthcare staff. In response to CG's question, AW confirmed these all relate to adults. CD asked what this high number of referrals represents and stated it is positive to see the amount of resource dedicated to safeguarding. AW thanked CD and noted that this is one of the advantages of an integrated health and social care system. AW confirmed that the conversion of referrals to formal investigations is not high. However actively encouraging referrals helps an understanding of what is going on in the wider health system.

CS asked JM / AW how confident they are that staff (irrespective of role / grade) would know how to escalate a safeguarding concern. JM advised that the second week of care rounding was held earlier this week with a focus on safeguarding and every staff member (multi-professional) spoken to had either attended Level 1 or Level 2 safeguarding and knew what to look out for and how to appropriately escalate concerns. All wards across the hospital were included.

CB reflected on his experience of attending the AO Group for safeguarding and has concerns regarding the disparity of focus on adult safeguarding (particularly in view of volumes of adult referrals). DG in agreement that this needs to be addressed urgently. DG shared a slide showing the framework for the oversight of safeguarding children in Jersey which is large and potentially detracts from operational safeguarding activity. It is likely that the framework for oversight of adult safeguarding is less.

DG surmised that the focus should be on who is doing the safeguarding activity in the first instance rather than the committees that oversee this activity. A piece of work to ensure parity between adult and children's safeguarding is required.

CD concluded that there is a huge amount of work and resource dedicated to safeguarding. However, it would be helpful for both the Quality, Safety and Improvement Committee and the HCS Safeguarding Committee to go through the JCC standards to make sure it is satisfied that every standard is being met as well as possible.

DG was thanked for his attendance at the meeting.

9	**Quality and Performance Report (QPR) Month 4**	**Action**

EH took the paper as read and highlighted some key points,

- It is regrettable that there are long waits within elective care services. For assurance, the longest waiting patients are constantly reviewed both clinically and through validation work. There has been no harm reported to-date.
- Improvement can be seen in some services, namely those that have received focus as part of the waiting list initiative schemes. The outsourced cataract pathway has received good feedback and patients have been requesting to go back if the other eye requires surgery.
- Continue to see an overall reduction in the outpatient waiting list.
- A recently recruited consultant has significantly reduced the waiting times in the Stroke and TIA pathway.
- A significant improvement can be seen in the inpatient waiting list, particularly for those waiting > 52 weeks.
- Theatre utilisation has improved for the 4th consecutive month.
- Those areas where less of an improvement can be seen (Gastroenterology) are those with a capacity issue (lack of resource). However, a gastroenterology Consultant will be commencing in July 2024 and until this time, the service is supported by some additional locum capacity.

- The new Gastroenterology Consultant will also provide additional endoscopy capacity. A waiting list initiative was undertaken for endoscopy services in November 2023 and March 2024 which significantly improved the waiting times. A slight increase has since been noted but this is expected to reduce once the additional Consultant is in post.
- The dermatology waiting list remains significantly high (both new patients and follow up) and this is due to lack of capacity within the service. Recruitment continues for a substantive Consultant dermatologist and hopeful that a suitable candidate will apply. Dermatology is a compromised service across the UK. In the short term, additional capacity will be provided. For assurance, all urgent dermatology referrals are being seen within the correct clinical timeframe (2 -4 weeks).
- An increase can be seen in diagnostic MRI. A pilot initiative concluded in January 2024 and reduced the waiting times to 6 weeks. Some additional capacity has been provided since this time (not as much as in the pilot), but the waiting times have risen. The pilot will be implemented as a sustained service in July 2024, and it is anticipated that the waiting times will reduce back to 6 weeks. For assurance, all urgent referrals are clinically prioritised and will be seen in the 2-week target.

CD asked about the impact of increasing services for private patients on the waiting list for public patients and sought a categoric assurance that private patients are not prioritised over urgent public patients. EH responded that all patients (irrespective of whether public or private) are clinically triaged and the most urgent patients are prioritised above all others. This is monitored daily. Whilst reassured by this, CD commented that if the number of private patients is increased, those non-urgent public patients must be waiting longer. EH responded that if the private patient throughput is increased, the private capacity should increase. The pilot showed that the impact of increasing the private throughout had a positive impact on the ability to deliver a better public service.

CG suggested that rather than continually focusing on the number of people waiting for an MRI, it would be better to understand why so many people are referred for MRI scans and how many of these are positive / false positive. CG speculated that the number of people referred for an MRI is high. CG reminded the Board that an MRI is a diagnostic test and whilst acknowledging there is no evidence, appears to be overused (reflecting on her own 35-year experience as a GP having only referred two people directly for an MRI). A paper from England's Emergency Departments showed that during 2023, £5 billion of unnecessary investigations took place through the ED regarding MRI and other diagnostic tests.

Acknowledging the validity of CG's point, AN (as an ED Consultant) responded that a negative test is sometimes more important than a positive test as this facilitates a safe discharge; negative tests do have value. However, an over reliance on diagnostic tests can result in loss of clinical judgment skills. Therefore it is important to use the available technology with the appropriate protocols and guidelines in place. CG noted that the MRI activity is not generated through the ED (otherwise they would not be on the list), but unnecessary diagnostics result in increased length of stay etc.

Regarding the quality impact on non-urgent patients from increased private activity, CS stated that the Medical Director and Chief Nurse have requested a patient-by-patient deep-dive through the monthly care group governance meetings (due to start June 2024). CD noted this is reassuring and asked the Board to be updated if any exceptions are noted.

Noting the absence of a comprehensive suite of social care indicators, AH advised the Adult Social Care Development Event in June 2024 will help to reinforce what a good social care system looks like, how this supports wellbeing generally and reduces demand over time on hospital services. Noting that the QPR is still very much hospital focussed, out of hospital indicators must be looked at in the round.

CD stated it is positive to see action being taken and the reduction in those waiting > 52 weeks. However, the public perception does not reflect this and asked why this data is questioned a lot – is there anything that can be done to give the public greater confidence in the data? CB commented that some of the public speculation may be because of personal circumstances however, there is no reason to believe the current information is inaccurate. CD thanked CB / EH

for this reassurance and remains hopeful that perceptions will change as the waiting lists continue to reduce.	

10	Workforce Report Month 4	Action

CB re-emphasised the need to correct the data regarding vacancies and sickness absence.

Other key points,

- Planned recruitment activity (noting the update provided by AW for MHS in agenda item 7).
- Law at Work Exit interviews – the reasons for people leaving. This will be reviewed in detail by the People and Culture Committee.
- Strategic Workforce Planning: anticipated progress for 2024 has not been made. CB is working with other senior civil servants across GOJ to discuss how to approach the development of strategic workforce plans. The New Health Facilities and changing demographics are just two examples that will drive workforce planning. JG endorsed the necessity of doing this work, firstly to prevent recruitment issues causing operational issues and secondly, creating opportunities around available skills. However, this work should be driven by an acute services strategy and the Board should mandate this as an opportunity to start to consider what an acute services strategy would like (under a whole Island Health and Care Strategy). CB noted the importance of the inclusion of MHS in this.
- Staff appraisal: objective setting has improved from 27.5% to 41.4% (excluding manual workers).

CG thanked the executive team for their hard work in this area. CG asked if the absence data relates to long-term sickness or large amounts of episodic illness. CB advised that this data is available but in the absence of a Director of Workforce at the meeting, unable to provide the specific split. AW confirmed that in MHS / ASC the overarching sickness data is significantly skewed by a very small number of long-term absences. In general, there is far more short term (1-2 days) absences.

CG asked if the lack of Occupational Health remains an issue. CB responded that this service is provided by the GOJ and People and Corporate Services are currently reviewing what the service should be in the future (as it is believed this service could be strengthened).

CD accepted the data is incorrect but asked why it is wrong. Incorrect data erodes confidence however the People and Culture Committee will start to deep dive into some of these areas when it meets in June 2024. CB explained that the data inaccuracies arise from trying to reconcile three different sources of workforce data: the Connect system, the Finance system and the operational services. The disparity between systems has been a long-standing concern for the Executive Team and unable to give an answer for why this is still occurring. CD acknowledged this must be very frustrating for managers.

Reflecting on the excellent nursing appraisal report provided by the Chief Nurse at the meeting in April, CD stated that this shows senior nurses taking serious responsibility to undertake these. CD directed that the best practice demonstrated within nursing should be transferred across the workforce to further increase organisational performance. Recognising the appraisal process is different for Doctor, CB stated there is a renewed effort (working with the Essex Deanery) to improve the quality of medical appraisal. This is not recorded in the Connect system.

Regarding the Law at Work Exit Interviews, CD commended HCS for commissioning the report and publishing the themes as it is not positive reading. CD noted that approximately 66% of people leave because of what could be classified as cultural issues. Whilst the GOJ undertakes larger surveys, HCS must start undertaking pulse surveys to understand how the workforce is feeling. CP advised that a Pulse Survey will be launched on the 3rd June 2024 with six statements. The purpose is to gain a quick understanding of how the workforce feels. A further Pulse Survey is planned for Sept, and this will be GOJ wide. CD advised that whilst the People and Culture Committee will look at these in detail, the results must be seen by the Board. It is very concerning that 66% of leavers are doing so because of cultural issues.

CP further advised that the Culture Dashboard will be presented to the Board in July 2024 which will include a spectrum of elements of culture.

ACTION: The results of the Pulse Surveys to be presented to the Board.

AH reflected that it is important to understand the experience of staff and whilst surveys provide some data, this does not replace having conversations with staff and sharing what we learn.

11	Finance Report Month 4	Action

OH took the paper as read. Key points,

- The Financial position for YTD Month 4 is an £8.3m deficit vs budget giving a headline monthly run-rate of £2.1m.
- Adjusting for one-off items and non-recurrent costs the underlying run-rate is £1.8m.
- FRP savings delivered are £2.4m vs £1.84m plan, made-up of £1.2m of original schemes and £1.2m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.
- FRP savings will initially be recognised against the GoJ Value for Money (VFM) target for HCS of £3.986m which is included as part of the FRP target of £12m for FY24.
- Exceptional items include backpay, Operation Crocus, drug inflation costs and non-pay inflation which is higher than funded amounts.
- The current FY24 year-end forecast remains a deficit of £18.0m. The key factors driving the forecast deficit are budget cost pressures £7.5m, FRP savings slippage due to delays in enabling support £6m, exceptional one-off costs in-year, Tertiary care contracts price inflation, activity increases in high cost-low volume (HCLV) services, drugs and other non-pay inflation, WLI funding, and additional costs of implementing the recommendations of Royal College reviews into Medicine and Maternity Services. The response to this is to continue working on mitigating actions and proposals and ideas have been shared with the Board and the Ministerial Team. However, unless the budget envelope moves, additional savings must be made. Ultimately this will be a political decision.

CD noted that the financial position is not changing. The £18m of reductions has been shared with the Ministerial Team and discussions are now being progressed politically. The NEDs have met with the current GOJ CEO and expressed concerns regarding the budget situation and received assurance that this is being dealt with as a GOJ wide issue (rather than HCS). However, there will be implications for other GOJ services as the GOJ seeks to balance the budget. The Board will await the outcome and the NEDs were reassured that the position would be known by July 2024.

12	HCS Response to Jersey Care Commission Single Assessment Framework Consultation	Action

CB explained that following the JCC presentation at the last Board meeting HCS has consulted widely (internally) on the proposed standards. In summary, HCS remains totally committed to the introduction of regulation and overall fully supports the principles and standards. There are a couple of specific comments (Appendix A) which will be sent to the JCC with a covering letter.

In addition, the second consultation (on legislation that will require the Jersey Care Commission to regulate hospital and ambulance services) has been considered. There are a number of technical issues that have been sent for comment by the Law Officers Department. HCS remains concerned about the issue of Registered Managers as the suggestion is that each ward / service manager is the Registered Manager. HCS does not consider this appropriate, and this does not the follow the CQC model – this responsibility sits with Chief Executive Officer and the designated Executive (Chief Nurse). Having multiple Registered Managers, some of whom will be junior members of staff is not something that HCS encourages.

CD thanked CB for his response and suggested that the latter should be included as part of the JCC response.

AH noted that Jersey is unique, and it is important that this framework recognises and captures this. AH emphasises this is not solely a hospital inspection; it includes community services, and it is important the Board has a sense of how HCS stands against the standards and what this means for future improvement work. CB responded that a gap analysis is being undertaken.

AM suggested that each Board agenda should feature an area included in the standards to aid understanding and identify potential gaps. Partnership working has been scheduled for Sept 2024. CD in agreement and hoping that the Director of Public Health will be able to attend in July 2024 to discuss the wider prevention programme.

CD suggested that the points made in Appendix A could be expanded when the response is returned so there is no misunderstanding and also include the concern regarding the second consultation.

The Board agreed this as the basis of the response to the JCC.

13	Outcome of the Root Cause Analysis of Deep Tissue Injuries	Action

JM took the paper as read and reminded the Board that this was drafted following an increase in pressure injury experienced by patients in hospital during March. A root cause analysis was undertaken for each incident and the theme of the damage related to the incorrect sizing of anti-embolism stockings (also known as compression stockings). These stockings are specially designed to help reduce risk of developing deep vein thrombosis (DVT) or blood clot in the lower leg. In response, organisation wide training and education was enacted to ensure correct measurements are taken to ensure the correct size stockings are applied to prevent future recurrence. A check has also been carried which showed that the training put in place has been followed.

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

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

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

Additional ongoing work to support the prevention of pressure damage includes participation in the National Mattress Audit (8th May), review of pressure relieving devices available, care review rounds, workforce training and the launch of the Pressure Ulcer Prevention and Management Framework.

ACTION: Pressure Ulcer prevention to be monitored through the Quality, Safety and Improvement Committee.

14	Maternity Improvement Plan	Action

RBB in attendance and took the paper as read. Key highlights include,

- The refurbished maternity unit was officially opened on 8th May 2024 (note the paper incorrectly states 5th May 2024).
- Working towards the publication of the Maternity Dashboard
- Ongoing linkage of the breastfeeding and perinatal mental health support services
- Assurance of ongoing progress of remaining open recommendations, some of these are long-term, such as Culture.
- The Maternity Strategy is on target to be delivered for publication at end of June 2024.

- First perinatal mental health training modules have commenced for all midwives, support worker and doctors.
- Whilst the outcomes of the Niche Report were planned for presentation at the Board today, these have not been through the HCS governance processes yet and is deferred until July 2024. The reason for the delay is Niche were unable to present until 31st May 2024. An action plan has been developed by RBB and the patient safety midwife and will also be shared with the Board. To note, the NICHE report has not highlighted any new concerns with a significant number of recommendations having already been completed.
- The culture improvement plan will continue through June 2024.
- Following reconfiguration of the SHIP Integrated Care Board (ICB), HCS to align with this ICB.

CD asked if SHIP Maternity Services are regulated by the CQC. CS confirmed that Portsmouth is rated 'Good', Southampton are 'Good', Isle of Wight are 'Good' and unsure regarding Hampshire. CD reassured that HCS is benchmarking against organisations that are largely 'Good'. RBB confirmed that SHIP is one of the best ICB across England. SHIP was selected for this reason and because babies from Jersey are transferred to these hospitals. CS advised the Board of the Maternity Incentive Scheme where maternity units receive insurance rebates if they provide high standards of care. All units within SHIP received this status.

CB explained that the Maternity Strategy has been produced in response to a scrutiny recommendation and represents a long-term view of maternity services in Jersey and the challenges that a small healthcare jurisdiction presents (with a reducing birth rate). The date of publication will be determined by the Ministerial team.

CD reminded the Board that as progress has been so good, this should now be business as usual with monitoring at the Quality, Safety and Improvement Committee with escalation of items of concern to the Board. In addition, maternity indicators are included within the Quality and Performance report.

CD highlighted that the issue most difficult to determine is of culture – even with all the processes in place, how will we know when the culture has changed? CD sought to confirm that maternity will be targeted through one of the Pulse Surveys. CP confirmed that the whole workforce will be invited to complete the Pulse Survey and results will be available for specific areas. However, additional culture work (including listening events) will be carried out with maternity services. CD stated that the Board should receive feedback from the listening events to be reassured regarding the culture change (in addition to process and system change).

ACTION: Maternity feedback to be included in the next culture report to the Board.

In response to CS's question, RBB confirmed that the maternity unit is viewed as a multidisciplinary team (midwives, doctors, support workers, anaesthetists). RBB confirmed this is the approach taken in the NHS.

From a strategic level, AM commented that the Board should see on a quarterly / biannual basis progress against the strategy and are services developing according to the strategy.

ACTION: Progress against the Maternity Strategy to be monitored by the Board every six months.

An additional area of concern highlighted by CD is how do the women who have been in the maternity unit feel, what does it feel like for them and how can we determine this more regularly (than the Picker Survey). RBB responded that the Maternity Unit works closely with Maternity Voice Partnership and Baby Steps. Other communities have been reached out to for inclusion, however this is an area for improvement work. CD also suggested inclusion of women who have experienced traumatic births.

CD thanked RBB for her attendance.

15	**Medicine Improvement Plan**	**Action**

AN noted the Maternity Improvement Plan as an exemplar that Medicine will replicating to progress their improvement work.

- The Medicine Care Group had a large number of recommendations from multiple reviews (some of which were duplicated). These have been collated and consolidated, totalling 70 recommendations.
- A Head of Governance (Interim), dedicated Project Management Support, external physician advisory support and an assistant general manager are supporting the medical care group to deliver against the recommendations.
- Engagement with staff is key. The first Mortality and Morbidity meeting for five years has been held with 64 in attendance.
- Care Group Governance meeting had over 9 Consultants in attendance at the last meeting.
- The fifth inset day will be held next Monday, and it is oversubscribed with a waiting list.
- First strategy meeting held.

There is a lot of activity, and it is anticipated that progress will pick up pace, especially with the additional resource to focus on governance.

There was a discussion about where the medicine improvement plan would be monitored. CD concluded that as progress has been slow, it should be presented to the Quality, Safety and Improvement Committee in advance of the Board. The QSI Committee can raise the serious issues of concern at the Board meeting.

CG thanked AN for the openness of the report and acknowledging that progress is slow. CG offered to meet AN to discuss how she may be able to support this work.

CB noted that a key issue is Consultant presence on the ward, attending ward / board rounds etc. which is standard practice in healthcare jurisdictions across the world. CB reflected on a recent discussion with Dr Ian Sturgess (external physician advisory support with expertise in patient safety and operational flow improvement) and felt reassured that progress is being made in this rea. However, additional issues were raised such as facilitating earlier discharges and there is significant activity within HCS's control to improve this.

- A second Gastroenterologist Consultant, a Stroke Consultant (frailty registered) and an Acute Physician have been recruited. The appointed Stroke Consultant is a well-respected lead for Stroke Services and is keen to develop a proper Stroke Service in Jersey (though investment may be required). The Consultant has also been able to clear the waiting list for those who have experienced a Transient Ischaemic Attack (TIA) (in a 3-week period).

Noting the reference to the Patient Charter, CD stated it would be good for the Board to have sight of this. This charter has been developed by the Patient Panel for use across the organisation.

CD asked what the difficulties are regarding blister packs. AN described the current process which takes up to seven days. CD asked why HCS cannot produce blister packs. AN advised that the work needs to begin with defining what the service needs to deliver and what needs to be done to deliver it. There are issues regarding pharmacy capacity and governance. CG noted that hospitals in the UK do not discharge patients with blister packs and this is complex.

CD thanked AN for the candidness of the report and stressed that more progress must be evident at the meeting July 2024.

16	**HCS Annual Plan**	**Action**
Noted for information. AM advised that the document has been updated following feedback and now includes commissioning and other items. The plan will be published on the HCS website and will be available to all staff. HCS is ahead of other GOJ departments who have not yet developed an annual plan. Reporting on progress will come back to the Board. In addition, AM		

suggested it would be beneficial to start discussions in July 2024 regarding the Annual Plan 2025 (approved by January 2025). ACTION: The Board will receive a Q2 report regarding the annual plan in Sept 2024.	

	Questions from the Public	Action
Member A: *The Health Minister was asked by Scrutiny Assisted Dying panel to publish an update and progress of the actions on the Palliative Care and End of Life Strategy before the Assisted Dying debate on 21st May. However this update was not available although the report (and action plan) was published in October 2023 due to the working group needing to approve it. It is now due to be published by the end of July.* *Does the Board think this should be part of this Board's action plan and monitored in the same way as the maternity improvement plan given that the Assisted Dying Route one has been passed in the Assembly?* AM in agreement. A paper will be presented at the HCS Senior Leadership Team meeting during May 2024, and this should then feed up to the Board (July 2024), so the Board has visibility of progress including what is in place, what is planned if any gaps identified. ACTION: Palliative Care and End of Life Strategy update to be presented to the Board in July 2024. **Member B:** *Over the last few months HCS has stated they have adopted a zero-tolerance policy on racism which is exactly as it should be. With the election looming in the UK, Heston interviewed the Shadow Health Secretary Wes Streeting last week on TV who stated that he was aware that there was a culture that silences brave NHS staff who act as whistleblowers and puts protecting the reputation of the NHS over protecting patients and that it has got to stop. He said that a labour government would put patient care first, protect whistleblowers and sack those who try to silence them. These people would face immediate loss of office with no pay-off and we would ensure that they were never employed in the NHS in any role ever again. Are you prepared to confirm as of today you will adopt the same zero tolerance policy on bullying as you do on racism including bullying by management especially when it includes bullying, intimidation, harassment and hostility towards whistleblowers. If possible, will you ensure that any such people are reported to the NHS so this would also preclude them from being employed there as well?* (intended for the Minister for Health and Social Services but redirected to CB in his absence). CB advised he was unable to speak for the MHSS. CB confirmed that HCS has zero-tolerance of bullying. There must be evidence of bullying and upon investigation, it is not always the case that bullying has occurred. The Junior doctor that raised concerned regarding rheumatology was well supported and hopefully this encourages other whistleblowers to step forward. The Executive team meet with whistle-blowers frequently and are provided with support as these people are identifying concerns in care. There is a zero tolerance of intimidation of staff who wish to speak up and any instance will be investigated with action taken as appropriate. This is common sense in healthcare as people need to feel safe and must be able to speak up. There was agreement that bullying can also occur amongst peers, from managers to staff and upwards from staff to managers. Deputy Howell confirmed it is a priority of the current Ministerial team that bullying will not be accepted and the culture of the healthcare service should be as good as possible. AN responded that culture and communication are key (noting that whistleblowing is a very emotive word) and makes himself available / approachable if staff want to speak with him. This begins to change the culture and whilst there is a long way to go, the culture in medicine is starting to change. Establishing the facts is very important before taking action. However, often it is about discussing concerns and learning from them. Member B acknowledged that bullying is subjective and recognised that some staff can mistake for performance management for bullying. However, the above is in relation to clear bullying. CB	

reinforced that any individual who is bullied and / or asked not to speak up, this is a very serious matter.

CD advised that whistleblowers must be protected and HCS should seek to do this on all occasions. In addition, whistle-blowers should be provided with more than one route to raise their concerns. Jersey does not have the legislative framework that the UK has to protect whistle-blowers.

CD concluded that the real issue is culture. Member B thanked the Board for the assurances given.

Member C: *Member C asked if the same principles apply if doctors bully patients, using a recent personal experience where it was alleged that a recent comment was made to her.*

CD advised that if a doctor or any member of staff has made a racist comment, this should be reported and suggested this is discussed with CB.

Member C went to further to say that during a recent hospital stay, there was no pressure relieving pump available for 2 weeks and the HCA was unaware of how to measure / apply TED stockings. Also 'difficult' patients are left to sleep rather than turned. In addition, the reason for the lack of confidence in the data is due to the messages communicated by frontline staff – member C indicated that she was told she would have to wait at least 6 months for her MRI scan. Member C also highlighted that she had remined in hospital unnecessarily for IV antibiotics which could have been administered in the community (putting her at risk of hospital acquired infections).

CB unclear as to why any member of staff would have informed her that there is a 6 month wait for an MRI scan – this is not true. This needs to be investigated with the department and the outcome fed back privately to member C. JM will pick up the issue with the TED stockings.

Member D: *Regarding the lack of confidence in the data, member D stated that an individual has been told that he must wait for 1 year (with a waiting list of 200 patients) and please can you explain what you intend to do about this as I understand that no-one should wait longer than 6 weeks for a heart scan (CTCA) – life is in danger.*

EH explained that some work has started on the CTCA waiting list. In part there is a lengthy wait for a CTCA, however as previously stated all urgent cases are receiving the CTCA within an urgent timescale. The cardiologists and AN (Chief of Service) are developing a business case to support CTCA capacity. The CTCA waits are not currently reported, and CB emphasised this is different from a CT scan. CG asked what the wait is for a private CTCA scan but EH unable to provide this during the meeting. EH confirmed that the target for all urgent referrals is 2-3 weeks. A member of the public suggested that the private wait is 2-3 weeks regardless of urgency but EH confirmed this is incorrect. CB confirmed that if the patient referred to in the question was an urgent referral, he would be seen within 2-3 weeks – the Board concluded that he could not been referred as urgent. The Board was reminded that all referrals are triaged by the cardiologists. More generally, all referrals are triaged clinically (specifically not managers or administrative staff). CD referred to her earlier point that regarding the data, this is not what the public believe they are experiencing on the waiting list, and this can only be resolved by reducing the waiting lists considerably. A general discussion followed about miscommunication leading to lack of confidence in the data.

Member D asked if HCS is not receiving enough money to deal with the waiting list.

CB explained that the allocation of additional funding means that HCS could see more patients and reduce the waiting list (as demonstrated through recent insourcing / outsourcing initiatives). However, this is also dependent on recruitment, and this will be difficult in some specialities i.e. ADHD.

CD concluded that the main issue is communication and speculated that it could be that the right message is communicated but people don't like the honesty of the communication (noting this is a different matter).

Member E: *You mentioned that MRI waiting times are back up, where are they at the MRI waiting times?*

EH responded that the current wait is approximately 20 weeks.

In addition, *as far as you are aware no harm is being caused to people on the longer waits of to a year. How do you measure this and what do you consider harm?*

EH responded this is a clinical decision. The clinicians will review their waiting lists – some patients will be invited back to a clinic for a review and others will be a review of clinical notes. However, it is always determined by the clinician. Potential harm will vary according to the speciality and used rheumatology / gastroenterology as examples.

Member F: *We have heard about resourcing in the stroke / TIA waiting times by appointing a stroke consultant that save approximately £100,000 / year in locum costs. It took 5+ years to make this appointment and this is why we are having problems with acute medicine. We have seen a reduction in MRI waiting lists by pump priming a waiting list initiative with £100,000 and doing a 70 / 30 split of public and private. The private income generated from this paid for the initial £100,00 and this was a fantastic initiative of balancing public and private. The waiting list for endoscopy reduced with a cost of £800,000 as despite the two of us (before I retired) the waiting list continued to go up and now just recently appointed a second, I don't think things will change that much despite the £800,000 expenditure. The £18 million pound overspend is mostly on costs of people /locum / agency costs and by appointing substantive posts (consultants, nursing, physios) will save a lot of money by simply making appointments. We have clearly seen patient lists are completely dependent on not only recruitment but also retention of staff and that's what we need to do in terms of cultural change, in terms of looking at why people are leaving using the exit interviews which have just started. Unfortunately the culture has been developing over the past 15 years in my personal experience and only with the inception of using exit interviews we have realised there is a cultural problem. If we can pinpoint the line managers responsible for the departure of those individual frontline workers, then they need to take responsibility and ownership and they need to be taught how to manage their workers. As already illustrated, the cost of healthcare is substantial, and for the Treasury Minister to ask us to save money is ludicrous because really healthcare inflation is way beyond retail price of inflation. Really, we should be given the £18million rather than asked to save the £18 million. I would urge the Advisory Board to help clarify with HCS politicians that we really need more investment, we need cultural improvement in order to reinforce the future of our islands healthcare particularly with extra costs incurred by the multisite new hospital facility.*

CD thanked Member F for the comments and advised that there was nothing which the Board would disagree. The point regarding investment relates not only to the immediate deficit but also consider the investment need for a different Island healthcare system which will focus more on prevention – however, this is political issue and will take time. In addition, the financial points reflect the discussions held with the GOJ CEO yesterday (Tues 29th May) and Ministerial discussions.

Member G: *Noting the points made about the recent consultant recruitment, what is happening with Primary care i.e. the interface and the impact that primary care can have on the waiting lists. Has the development of specialist nurses been considered as good examples exist within gastroenterology, cardiology and many other areas.*

CG responded that international healthcare systems will not be able afford its healthcare unless it starts to transfer care out of hospital and invest in primary and community care and prevention. This will be discussed further at the Friends of Our New Hospital Healthcare Conference on 27th June. The different budget lines in Jersey make it more difficult to move resources and start to redesign services, however it is not impossible. CG will be starting to engage with the Primary Care Community and holds the view that much of current activity could be better managed further downstream. There are gaps in Intermediate Care and the use of digital. Closing these gaps could start to recover the current inflation costs. CG feels the point is well made and hopes to bring back further discussions to the Board.

CB advised that HCS meets with the GPs as part of the Primary Care Board (monthly) where a whole range of issues are raised. Using the example of gastroenterology, the use of specialist nurses is effective and specialist nursing is encouraged as all professions acting to the top of their registration. If the funding was available, more specialist nurses (and other specialist professionals such as AHPs) would be appointed as a fundamental part of the multi-disciplinary team. Member G responded this is a good to hear and was also thinking about primary care working within the secondary care setting. CG responded that this should be approached with caution as GPs would rapidly become secondary care minded and start to behave like Consultants. GPs are used to dealing with risk and uncertainty. CG stated that this has not worked in the UK. **Member H**: Reflecting on the discussion about affording whistle-blowers protection, should the same protection be afforded to patients who make complaints. CB responded that patient should not be afraid to complain as they fear that they may be treated differently (worse). Patients that raise concerns need to be protected and if any patient believes that they are receiving poor care as a consequence of raising the complaint they must contact CB or one of the Executive Directors – this is completely unacceptable. Member H stated this has been her experience and has been in contact with the Medical Director who has been helpful. This is inline with recent press coverage of complaints. JM will progress this individual case.	

	MEETING CLOSE	**Action**
CB thanked everyone in attendance for their contributions and advised that she will be on leave for the next meeting; AH will Chair the meeting. **Date of next meeting:** Thursday 25th July 2024		

	A	B	C	D	E	F	G	H	I	J	K
1	HEALTH AND COMMUNITY SERVICES ADVISORY BOARD - ACTION TRACKER (OPEN)										
2											
3	**Action Number**	**Meeting Date**	**Agenda Item**	**Agenda Description**	**Action**	**Accountable Executive**	**By When**	**Progress report**	**Escalated to / when?**	**Action Closed Date**	**Status**
4	146	30-May-24		Questions from the Public	Palliative Care and End of Life Strategy update to be presented to the Board in July 2024.	Dr Anuschka Muller	Jul-24				July Agenda
5	145	30-May-24	16	HCS Annual Plan 2024	The Board will receive a Q2 report regarding the annual plan in Sept 2024	Dr Anuschka Muller	Sep-24				Sept Agenda
6	144	30-May-24	14	Maternity Improvement Plan	Progress against the Maternity Strategy to be monitored by the Board every six months.	Patrick Armstrong	Nov-24				Nov Agenda
7	143	30-May-24	14	Maternity Improvement Plan	Maternity feedback to be included in the next culture report to the Board	Dr Cheryl Power	Jul-24				July Agenda
8	141	30-May-24	10	Workforce Report Month 4	The results of the Pulse Surveys to be presented to the Board	Dr Cheryl Power	TBC				TBC
9	132	25-Apr-24	6	Chief Officer Report	On completion of the first cohort of peer reviews, the Board is to receive a summary of the outcomes (including any issues arising).	Jessie Marshall	Jul-24				July Agenda
10	129	28-Mar-24	9	Workforce Report (Month 2)	Invest to save options to speed up the recruitment process to be explored and brought back to the next meeting (April 2024).	O. Hasan	Apr-24				OPEN
11	127	29-Feb-24	14	#BeOurBest Programme - Annual update	CP to present the culture dashboard at a future Board meeting.	C. Bown	Jun-24	Update 28 March 2024 CP confirmed that the culture dashboard will be presented to Board in June 2024. Remain OPEN.			July Agenda
12	125	29-Feb-24	13	Mental Health External Review Implementation	CD asked for an update on the work to join up Mental Health Services and Acute Services as it progress (timescale to be determined)	A. Weir	Apr-24	Update 28 March 2024 AW confirmed that meetings have taken place between Mental health And Acute Services. A summary of this can be presented to the board in April 2024. Remain OPEN			OPEN
13	123	29-Feb-24	8	Waiting List Report Month 1	CT will present the fully validated waiting lists within the next three months	C. Thompson	by Jun 2024				July Agenda
14	121	29-Feb-24	7	Quality and Performance Report	CG and CT to discuss remote physiotherapy opportunities.	C. Thompson	Mar-24	Update 28 March 2024 Meeting between CG and CT to discuss remote physiotherapy opportunities to be confirmed. Remian OPEN			OPEN
15	114	25-Jan-24	7	Quality and Performance Report	AW to provide a paper on neurodevelopmental services in May 2024.	Andy Weir	May-24				OPEN
16	96	06-Dec-23	6	Chief Officer's Report	The board to receive a report indicating progress on increasing the number of ACPs (March 2024).	Jessie Marshall	~~01/03/2024~~ Sept 2024	Update 28 March 2024 The number of ACP's is to be increased – currently there a small number in post however a Project Lead has been appointed with start date 1st July to the position of Practice Development, Advanced Practice and Independent Prescribing who will support the further development of Advanced Clinical Practice across HCS in line with new NMC regulations due 2025/26. Anticipate an update after July 2024. Remain OPEN.			Sept Agenda
17	76	1st Nov 2023	4	Management of Incidents of Racial Abuse	Prosecution Policy to be presented to the Board (link to action 70).	Andy Weir	~~01/02/2024~~ May 2024				OPEN
18	31	10-Jul-23	13	Finance Report – Month 5	HMT and CB will discuss the lack of budgetary information available to budget holders with KPMG.	H. Mascie Taylor / Chris Bown	May 2024 ~~Feb 2024~~ ~~December 2023~~ ~~01/10/2023~~	Update 28 March 2024 OH advised that Treasury have confirmed that budget holders should have access to the budget data by end April 2024. Remain OPEN. Update 6 Dec 2023 It is anticipated that budget holders will have electronic access to their budgets in Jan / Feb 2024 (Q1 2024). To mitigate the risk, the finance business partners provide manual reports to the care groups monthly and accountable officers are held to account through the performance reviews. For a further update in February 2024. Update 4 October 2023 OH explained that the lack of budgetary information available to budget holders has been tracked over the last six months. Following the implementation of the new system, access rights were changed. The HCS finance team have been told that work to resolve this has been delayed with a revised timeframe of Quarter 1 (Q1) 2024. The HCS Finance Business Partners have limited access, it is the wider access across HCS that will take time. CB noted this was not a satisfactory position. To mitigate the risk associated with this lack of access, the finance business partners download the information and produce reports for budget holders. However, this is an inefficient (manual) process. OH provided assurance that there is a process in place to hold budget holders to account for management of their budgets including weekly meetings with the care groups and the care group performance reviews. The Board asked to be provided with an update at the meeting in December Remain OPEN.			OPEN

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Chief Officer's Report**		
Date of Meeting:	25 July 2024	**Agenda Item:**	**6**

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

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

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

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

List of Appendices:
Nil

MAIN REPORT

HCS 2024 Annual Plan – Q2 Progress

At the end of 2023, HCS developed our 2024 Annual Plan, which includes the department's key deliverables for the year. Whilst we have had some setbacks that have caused some due dates to be postponed, I am pleased to report that good progress has been made across the breadth of the plan.

The full Q2 progress report has been submitted to the Board for consideration. Additionally, please note that another related paper has been submitted to the Board for consideration, which lays out a proposal for how HCS will develop its plans for 2025 and beyond.

Dementia Strategy Launch

Jersey's first island-wide Dementia Strategy (Strong Foundations) was launched on the 28th of June 2024. The Strategy was jointly developed by the Government of Jersey and Dementia Jersey and sets out five key areas of commitment for the next five years: raising awareness, diagnosing well, supporting people with dementia and their relatives, valuing and developing the workforce, and developing Jersey to be dementia friendly and inclusive. An implementation plan outlining actions to be undertaken in the first 12 months of the strategy was also released, and work has commenced on the HCS actions identified within the plan.

Royal College of Radiologists Report

A report produced by the Royal College of Radiologists is to be considered at the Board meeting including an action plan to address the recommendations. In addition, a summary report and action plan regarding the mammography service will also be considered.

Rheumatology

An update report is provided on the rheumatology service including the latest position with the clinical review of deceased patients. The improvement plan was also considered at the Board's Quality, Safety and Improvement Committee chaired by Dame Claire Gerada.

Public Accounts Committee

I attended with Obi Hasan Financial Recovery Director a meeting of the PAC on 3 July 24 where the committee scrutinised the current financial position of HCS.

Patient Safety Conference

Patient Safety is integral to delivering high-quality healthcare and promoting positive outcomes for patients. The commitment of staff to ensuring practice remains safe and effective was recently demonstrated at the HCS Patient Safety Conference, held on the 11th of June at the Radissons

Hotel. 114 members of HCS staff in various roles across the organisation registered to attend and 100 signed in on the day.

The Keynote speaker was James Titcombe who is the Chief Executive of Patient Safety Watch, a charity that aims to improve patient safety and reduce preventable harm in healthcare. He is also a Patient Safety Ambassador for the Morecambe Bay NHS Trust, where he works to promote a culture of learning and improvement.

Other speakers included Dr Chris Edmonds, an Occupational Physician and the Medical Director of Work Health (Channel Islands) Ltd, Dr Bob Klaber who is a Consultant General Paediatrician and Director of Strategy, Research and Innovation at Imperial College Healthcare NHS Trust and Mr Simon West, Deputy Medical Director, Health and Community Services, and Consultant Orthopaedic Surgeon.

The feedback received captured the impact of the conference and the value of the learning. Delegates described the event as “interesting, incredible, engaging and well presented as well as being an important topic for HCS. The presentations offered practical advice which delegates felt they could translate into their own practice.

The Conference was well received and well attended and clearly demonstrated the commitment of HCS staff to patient safety

Florence Nightingale Foundation Leadership Course

The Chief Nurse's office is pleased to announce that the first of two cohorts of ward managers have begun a bespoke and innovative training program with the Florence Nightingale Foundation. This program aims to ensure that ward managers are accountable, confident, capable, and well-equipped to lead their teams and services with compassion and inclusivity. The training underscores the critical importance of visible and inclusive leadership across nursing and midwifery, in alignment with the Nursing and Midwifery Council (NMC) Code of Conduct.

CAIT Communication and Interaction Training (CAIT)

To broaden the knowledge and understanding of the care required when looking after a dementia patient, over 40 staff recently undertook CAIT training. CAIT training is a person-centred training programme which recognises the importance of dementia care literacy. It teaches staff about the importance of using the same strategies and language when caring for those with dementia. CAIT training is recognised as a best practice tool in clinical practice.

An action plan is being drawn up of some of the key interventions in nursing that can be implemented in practice to improve the dementia patients care and journey in HCS.

Ectopic Pregnancy Management

The HCS current pathways related to ectopic pregnancy and individuals attending the emergency department with pain or bleeding following a confirmed pregnancy are presently under review.

The initial review focused on identifying any immediate actions needed. We are now revising our patient information leaflets and seeking feedback from service users to ensure they receive the most relevant and appropriate information.

We are benchmarking our current guidelines to ensure our information and practices are up-to-date and in line with NICE guidelines.

The next steps include regular multidisciplinary team (MDT) meetings to thoroughly review all existing guidelines and implement any identified changes. Any training needs identified will be addressed to ensure staff are appropriately trained. Additionally, ongoing audits will be conducted to ensure that any implemented changes are effectively integrated into our standard operating procedures (business as usual).

St Ewolds

I was pleased to visit St Ewolds with Andy Weir, Director of Mental Health and Social Care, Samares and meet staff and patients who have settled in well. Whilst there were still some physical estate works that need resolution, the facility is of a high quality, and I would like to thank all colleagues who made this move possible.

Opening of Clinique Pinel

On 28th June we opened our newly refurbished Clinique Pinel and the staff and patients of Orchard House moved into the new “Orchard Ward”. The new environment is bright, spacious and will offer an improved therapeutic environment supporting patients’ recovery and will mean that Mental Health inpatient services are now provided on the same site. A huge amount of work went into the move from the inpatient team as well as colleagues across the facilities services and I would like to thank everyone involved. We will open the article 36 suite in the very near future and I will keep you informed.

Cultural Change (including Staff Engagement)

Our regular engagement and listening events have continued for all HCS staff. Our Stars is a Government of Jersey programme where colleagues are recognised for going over and above in their role and living our values. There is an award category for everyone in HCS whether they are teams, individuals, clinical or non-clinical colleagues and across all staff groups. In July, the nomination platform for Our Stars 2024 was launched and during the first few weeks HCS has recognised and nominated more staff than any other Government department. A ceremony will be held in November to celebrate and recognise our colleagues.

We recognise the importance of eliciting feedback from our staff in helping us understand what is working well in the workplace and what needs to be improved. A Be Heard Pulse Survey will be launched in September for three weeks to understand where HCS is across a number of engagement factors including leadership, management and wellbeing.

During May and June, we have celebrated several key achievements across HCS;

- HCS Foundation Doctors achieved a 100% Annual Review of Competency Progression (ARCPs) pass rate.
- The Cardiology team offered heart checks and advice to patients and colleagues as part of Heart Failure Awareness week.
- HCS launched a Stand Against Racism campaign

- Occupational Therapist Assistant in the Pain Service Department completed a Certified Disability Management Professional accreditation, to help support Islanders return to work.
- The Jersey Heart Failure Pathway was ratified and launched with HCS employees.
- The Respiratory Team set up a choir for Islanders with chronic lung diseases and put a call out for new members to join.

Finance (including FRP) - Obi

- FY24 YTD M6 deficit is £13.9m giving a headline monthly run-rate of £2.3m. Adjusting for one-off items and non-recurrent costs the underlying monthly run-rate is £2.1m.
- FRP savings of £3.6m have been delivered vs £4m plan at M6 made-up of £2m savings from original FRP schemes and £1.6m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.
- The year-end forecast is £24.2m deficit after delivering £5m of FRP savings, with further downside risks from cost pressures that may materialise during the year, before additional mitigation actions are taken.
- Recovery actions being taken include:
  - **Intensive recovery support** working with the Care Groups that have been placed under financial escalation with weekly Executive review and accountability meetings, to reduce the current overspend run-rate and continue delivery of FRP savings
  - **Further Cost Reduction Actions** - Due to the M6 deterioration in the financial position, urgent additional cost reductions and service reduction options are required in-year to remain within the mandated £24m in-year deficit budget.
  - **Sustainable long-term funding** - a paper has been submitted to Treasury and the MHSS for discussion at a forthcoming COM (Council of Ministers) meeting, making the case for additional funding to balance the position at year-end and to provide a long-term sustainable funding settlement for HCS.

Workforce

Following some data errors in the last board report I have asked the new Director of Workforce to undertake a detailed data quality review and report redesign so have suspended reporting until the next Board meeting in September 2024.

Waiting List Initiative Update

To support the continued reduction of patients waiting times in key service areas, the successful introduction of an additional three outsourced initiatives in the last quarter has positively impacted on patient experience.

- To date 166 patients have been booked to receive their cataract treatment in Southampton since Easter 2024, of these, 117 have already received their treatment. This initiative will continue to the end of the year with approximately 300 patients planned to be treated under this arrangement. Feedback has been very positive.

- The Cardiac ECHO initiative commenced in May 2024, with 448 patients receiving their diagnostic test out of the 1100 patients who will be booked through this initiative which is due to finish in September.
- A total of 100 patients are in the process of being outsourced for full orthodontic treatment with 8 of these patients already fitted with their fixed braces.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Update on the implementation of 'A Palliative and End of Life Care Strategy for Adults in Jersey'**		
Date of Meeting:	25 July 2024	**Agenda Item:**	**8**

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

Purpose of Report:	Approval ☐	Assurance ☒	Information ☐	Discussion ☐
	This paper provides assurance on the delivery of the Palliative and End of Life Care Strategy for Adults in Jersey			

Summary of Key Messages:

The key messages arising from this report are:

A Palliative and End of Life Care Strategy for Adults in Jersey 2023-2026 was published in 2023. This strategy identified, from international and local evidence, that as a community, when we or our loved ones approach the end of our lives we want to:

- Have choice about where we want to receive care.
- Be involved in decisions about our care.
- Be treated with dignity, respect and to be heard.
- Have access to support when we need it
- Be cared for by professionals who are well trained to deliver palliative and end of life care.
- Know that our loved ones will be supported.

To deliver this best practice from the international evidence the Jersey Strategy highlights the need to focus on:

- **Community awareness** -
  Target: To build on the annual Jersey Hospice Care Dying Matters Campaign, raising awareness across the Island about dying and its impact on each of us.

- **Holistic Support** – to provide the right support when it is needed, an initial holistic needs assessment should be carried out with the person and documented. This will enable consideration of all aspects of their wellbeing, spiritual, health and social care needs and ensure that their concerns and problems are identified so that support can be provided to address them. Introduce the Integrated Palliative Care Outcome Scale (IPOS)
  Target: Introduce IPOS by 2026. Jersey Hospice care is in the process of installing with support from GOJ.

- **Early Identification of Palliative Care** - Healthcare providers can be supported to promptly identify adults who are likely to be near the end of life by

using a systematic approach like the Gold Standards Framework Proactive Identification Guidance.
Target: Data currently collected and will inform the best practice target* 100% of health and care professionals working across community, hospital and hospice will have access to educational sessions around palliative care including GSF and end of life care monthly.

- **Gold Standards Framework** - Jersey is internationally recognised as the only jurisdiction to implement this framework across all its health boundaries, as cited by Prof Keri Thomas, the founder of the Gold Standards Framework (GSF)
  Target: Data currently collected and will inform the best practise target* 100% of health and care professionals working across community, hospital and hospice will have access to educational sessions around palliative care including GSF and end of life care monthly.

- **Advanced Care Planning** - Advance Care Planning (ACP) should happen after a holistic needs assessment to ensure that it fully takes into account all of the things that are important to the person. It is an ongoing process.
  Target: Data currently collected and will inform the best practise target* Q4 2023 88% known to SPCT with an ACP discussion Q1 2024 98% with an ACP discussion

- **Preferred place of care** - The preferred place of care is a person's choice of where they would like to receive end of life care. The preferred place of care can have a significant impact on the person's quality of life and their sense of comfort and dignity.
  Target: Data currently collected 75% of patients will achieve their preferred place of care* Q4 2023 81% known to SPCT achieved Q1 2024 73% known to SPCT achieved.

- **Treatment and Escalation Plan (TEP)** - "Treatment Escalation" is the process of increasing the level of care provided to a patient as their condition worsens up to a designated "ceiling of treatment" promoting a proactive, collaborative approach to end of life care planning and improving decision making in the event of a deterioration.
  Target: 75% of patients with an expected death will have documented advance care planning which includes a treatment escalation plan and DNACPR record. *

- **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)** - DNACPR decisions are an important aspect of advance care planning, and people should be fully involved in discussions about their care
  Target: 75% of patients with an expected death will have documented advance care planning which includes a treatment escalation plan and DNACPR record. *

- **Personalised Care Records** - The development of the "personalised care record for the last days of life" (PCR) incorporates all the patients' wishes and preferences enabling health care professionals to do all they are able to meet these needs.
  Target: in development*

- **Anticipatory Medications in the community** - Anticipatory prescribing means making sure that someone has access to medicines they will need if they develop distressing symptoms at home or in a care home. The medicines

	are prescribed in advance so that the person has access to them as soon as they need them. **Target**: in development* • **Integrated IT system** - The introduction of the electronic patient record system (EMIS) within the community has seen patient records being shared between General Practitioners (GPs), Family Nursing and Home Care (FNHC) and JHC and improved communication between community organisations. However, the information contained within the digital patient record is not easily available to all other health care providers and community plans are not visible in hospital electronic patient records or Jersey Ambulance systems. **Target**: in development* *A task and finish group is being developed to review and determine the outcome and performance measures to be completed for 2025. In addition, we are in the process of registering for NACEL (National Audit of Care at the End of Life) which will enable UK benchmarking informing data which will help to set targets and benchmark Jersey performance. Palliative and end of life care is very topical as States Assembly has agreed to take the Assisted Dying Bill forward. It is now crucial to ensure there are robust palliative care services across Jersey, so islanders have a real choice around end-of-life decisions and are not pushed into making any decision based on lack of alternative services. The strategic case was driven by a clear, patient-centred, operational and financial case for change and in line with Government of Jersey policy. The objectives are detailed as: 1. Ensure care is patient-centred and patient preferences are supported as they approach end-of-life. 2. Ensure care delivery is robust enough to support care both in the community and hospice thereby reducing dependency on secondary care. 3. Ensure there is robust financial investment in end-of-life care across the system to support all services in delivery of end-of-life care. 4. Ensure there is financial investment in education across the system to ensure care is delivered by a competent workforce and prevent movement of patients from a care setting due to lack of knowledge/skills or competence. 5. Ensure the model of palliative care services meets the objectives of the Palliative and End of Life care strategy. Progress against the Palliative and End of Life Care strategy includes: • Continued development of the Specialist Palliative Care Team • Increased funding support to Jersey Hospice Care in-patient services resulting in a greater number of people known to SPCT dying in hospice rather than hospital. • Increase in bereavement services resulting in faster access to the service. • Enhanced Island wide education plan developed and commencing in Quarter 3 2024 • Plans for enhanced care at home in final stages. This work is overseen by the End-of-Life Partnership which is a multi-stakeholder group chaired by the Palliative Care Consultant and inclusive of all partners including families and representatives of the patient's panel.
Recommendations:	**The Board is asked to note the report and support continuation of delivery.**

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

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
HCS Senior Leadership Team (SLT) Meeting	11 July 2024	Report and progress made reviewed. Request for regular updates at SLT

List of Appendices:
A Palliative and End of Life Care Strategy for Adults in Jersey

MAIN REPORT

In 2023 the Palliative and End of Life Care for Adults in Jersey was published alongside the existing business case which recognised:

'HCS currently commissions specialist community palliative care services from Jersey Hospice, with the Hospice using charitable monies to fund the in-patient service.

Our ageing population is creating increased demand on services and the current levels of funding are not sufficient to meet needs. This additional investment will allow the Hospice to continue to deliver specialist community palliative care, a system wide education programme to ensure a competent workforce across all sectors, support the in-patient service at Hospice and increase bereavement support.

This investment will also enable other providers to deliver an enhanced range of community-based services, supporting more people who wish to die at home. This is important because it will reduce reliance on a single provider of end-of-life services.'

Progress is being made in tandem for both the Strategy and business case:

To deliver the outcomes and deliverables within the business case and strategy an end-of-life partnership group has been established and is supported by working groups.

The strategy identified six outcomes:

Outcome 1 - People in Jersey who need palliative and / or end of life care will be seen and treated as individuals who are encouraged to make and share advance care plans and to be involved in decision.

Outcome 2 – People in Jersey who need palliative and / or end of life care will have their needs and conditions recognised quickly and be given fair access to services regardless of their background and characteristics.

Outcome 3 – People in Jersey who need palliative and / or end of life care will be supported to live well as long as possible taking account of their expressed wishes and maximising their comfort and wellbeing.

Outcome 4 – People in Jersey who need palliative and / or end of life care will receive care that is well coordinated.

Outcome 5 - People in Jersey who need palliative and/or end of life care will have their care provided by people who are well trained to do so and are receiving ongoing training to maintain their skills and competencies.

Outcome 6 - People in Jersey who need palliative and/or end of life care will be part of communities that talk about death and dying and that are ready, willing and able to provide the support needed.

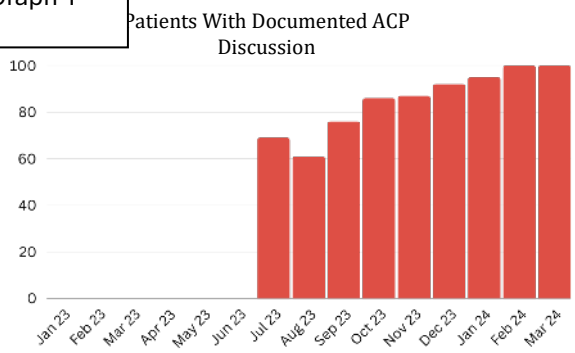
To deliver the outcomes four essential enablers were identified:

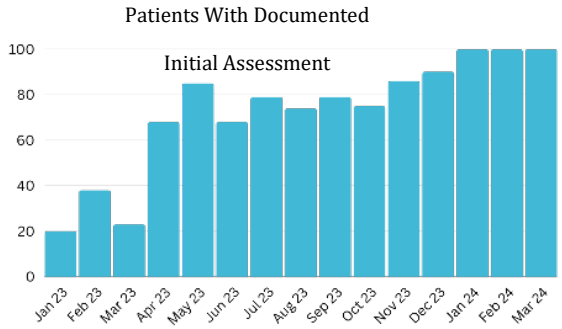
1. The use of technology to inform, understand and improve care
2. Education and workforce
3. Public and patient engagement
4. Co-design of island-wide palliative care pathway

Delivery of the strategy is progressing:

The number of patients with Advanced Care plans in the community known to the Specialist Palliative Care Team has increased from 67% October 2023 to 100% March 2024, with a similar picture for documented initial assessments.

Graph 1



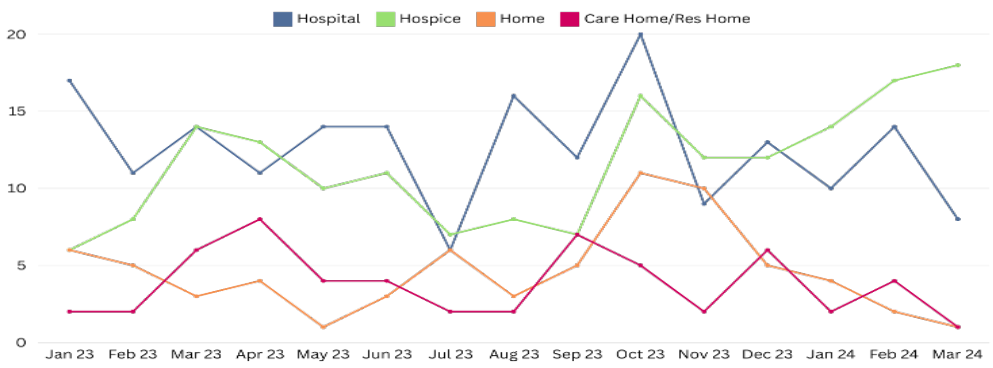


The partnership group is supporting the need for care to be integrated and developing pathways through the care at home work and an education programme for the island will commence role out over the next few months.

Inpatient Services: Partnership funding is in place increasing flow between hospital and hospice. The Inpatient Service facilitates hospital avoidance and achieving preferred place of care within the community.

Current activity demonstrates a positive trend with the place of death of people known to the specialist palliative care team (SPCT) changing with the majority of people now dying in hospice rather than hospital. The future work around education and care at home should see improvements during 2025 in people remaining within their home if this is their choice.

Graph 2

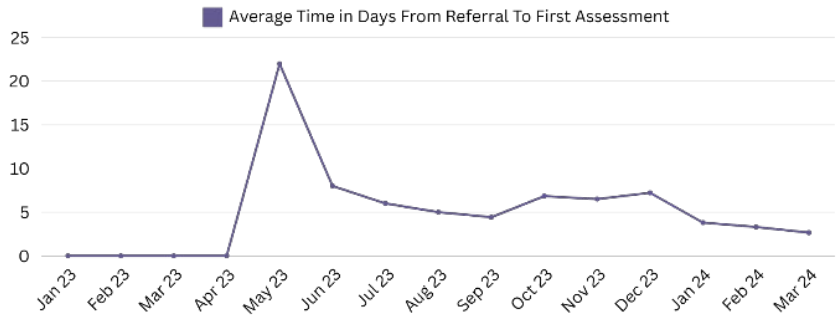


There has been consistently high number of admissions to hospice care with bed occupancy for the last three months at >80% with patient relative satisfaction scores at 100%.

Specialist Community Palliative Care Service: This continues although there have been recruitment challenges over the last 12 months. The service has maintained performance at current levels, but it is intended that when fully recruited to the team will support more people across the system.

Bereavement service: Partnership funding is in place and the service is extending across the Island. This has seen an improvement in access to the bereavement services with the average time in days from referral to assessment decreasing.

Graph 3



End of Life at home including day and outpatient services: Currently in the design phase. There are many organisations working in this area and an inclusive working group is designing how this can best work in Jersey. Plans are well underway for the service to commence in Q4 2024.

Education: A partnership has been developed to ensure education is rolled out across the island to all, including patients, families, carers/support workers, all care providers and clinical and hospital staff. Education programmes are running but this will increase in Q3and4 2024

The current unfunded gap is the technology to support across the system.

END OF REPORT

ID A Palliative and End of Life Care Strategy For Adults in Jersey.pdf (gov.je)

Progress against strategic Plan

Health and Community Services

Complete

Not Started

Current/ongoing

	2024	2025	2026	Update	Next steps
Outcome 1 - People in Jersey who need palliative and / or end of life care will be seen and treated as individuals who are encouraged to make and share advance care plans and to be involved in decision regarding their care					
Continue the development of Gold Standards Framework across health care professionals in the community and hospital				• Promoted through the education programme.	• ongoing
Develop a central, integrated IT system to facilitate the sharing of advance care plans and Gold Standards Framework recording and collate outcome performance data				• On hold. • Representatives of the partnership have contributed to updating the DNACPR policy in HCS which incorporates the sharing of resuscitation decisions.	• Plans to be developed during 2025.
Outcome 2 – People in Jersey who need palliative and / or end of life care will have their needs and conditions recognised quickly and be given fair access to services regardless of their background and characteristics					
Ensure all interested parties who represent patients requiring palliative care have a voice on the End of Life Care Partnership				• Patient representatives are members of the End of Life Care Partnership Group and working groups. • Wide breadth of representation across health and community partners including various charities.	• ongoing
Design and build a robust 24/7 model of palliative care that is accessible to, and meets the needs of, patients and families at a generalist and specialist level				• Plans developed for expanding specialist and generalist services. • Co-design workshops have taken place involving partnership group organisations	• Q4 2024 implementation of first phase. • 2025 next stage of development addressing: ○ overnight care,

				• with advice from a UK subject matter expert. • First phase to introduce new community nursing roles to support earlier identification of people at the end of life and advanced care planning.	○ access to equipment ○ financial support.
Educate / develop the workforce / volunteers and increase public awareness in relation to palliative care				• Proposals for an education programme have been approved. • 3 key areas (symptom management, advanced care planning and communication) have been prioritised for initial roll out. • Courses will be delivered by a partnership of HCS and Jersey Hospice education teams.	• Q3 2024 Implementation • 2025 review of phase 1 and training needs analysis • 2026 review and amend programme based on updated analysis of training needs
Arrange access to emergency funding for end of life care and to responsive care in the community at end of life either from the Long-Term Care Fund or alternative sources				• Delayed awaiting LTC review. • A cross government working group has been established to focus on this.	• Q3 2024 working group meeting scheduled
Collate Public Health data across all healthcare settings using a collaborative approach to IT systems and robust analysis with benchmarking				• On hold	• 2025 IT plan to be developed.
Outcome 3 – People in Jersey who need palliative and / or end of life care will be supported to live well as long as possible taking account of their expressed wishes and maximising their comfort and wellbeing					

Develop standard operating procedures across all partnership providers				• Standard operating procedures in development as part of the new care model work.	• 2024/5 Implementation
Improve and build on these community services and initiatives as we face an ageing demographic and therefore an increased need for these services				• Current services have been reviewed and gaps and improvements identified. • Gaps and improvements are being addressed through the service development work.	• Ongoing improvement process. • Changes implemented at the end of 2024 • Changes reviewed at the end of 2025 and • 2026 further improvements made as necessary.
Differentiate between specialist / generalist provision to ensure the most cost-effective model is designed with patient preferences built in				• Completed as part of the current service review and development plans. • Service specifications will be clear on the role of specialist and generalist provision.	• Changes implemented at the end of 2024 • Changes reviewed at the end of 2025 and 2026 further improvements made as necessary.
Ensure hospital referrals to community services are completed in a timely manner				• Ongoing progress. • Standard operating procedures and the education programme will support this action.	• Ongoing
Improve communication across all areas of the health system				• Built into education programme	• Ongoing continuous improvement process.
Develop a transfer of care process				• Built into service improvement plan	• Q4 2024 implementation

Develop an educational focus for GPs and care homes around advance care planning and end of life care to seek to and prevent avoidable admission to hospital		• Built into education programme	• Ongoing continuous improvement process.
Outcome 4 – People in Jersey who need palliative and / or end of life care will receive care that is well coordinated			
Ensure the right information is available at the right time to minimise duplication through the development of an integrated IT system across the whole health system in Jersey		• On hold	• 2025 IT plan to be developed.
Expand / realign hospital discharge processes to present the opportunity to enable more people to transfer from inpatient settings to their preferred place of care with the care they require to support them as appropriate		• Specialist palliative care team will retain responsibility for Gold Standards Framework and will provide in reach to inpatient areas to facilitate discharge.	
Ensure people receive the right care, at the right time, in the place consistent with their wishes and preferences avoiding the disruption of non-value added hospital admissions		• Ongoing. • The new nursing roles being created will support advanced care planning and ensure that people receive support earlier.	• Ongoing continuous improvement process.
Develop a single point of access for referrals to help ensure patients have timely access to the most appropriate care in the most efficient way possible		• In development of the new service model.	• 2025 Implementation
Develop an agreed pathway for access to anticipatory medicines / equipment out of hours		• Initial scoping work completed	• 2025 next stage of development which will address overnight care, access to equipment and financial support.

Address care needs to support people to remain in their own home				• Initial scoping work completed	• 2025 next stage of development which will address overnight care, access to equipment and financial support.
Outcome 5 - People in Jersey who need palliative and/or end of life care will have their care provided by people who are well trained to do so and are receiving ongoing training to maintain their skills and competencies					
Undertake a needs analysis of the health and care workforce in terms of their knowledge and competence in palliative and end of life care				• Initial priorities for education have been identified through incident and mortality reviews.	• A more comprehensive training needs analysis will be conducted as part of the new education service through 2025.
Develop an island wide training plan and competency framework to support the entire workforce				• Initial training plan developed.	• Q3 2024 Implementation • 2025 competency framework developed
Develop consistent measurable standards and robust evaluation methods for quality education and training and ensure it is delivered by skilled and qualified providers				• Key performance indicators identified within education plan. • A variety of methods to evaluate the quality of training identified. • Approved providers, appropriately skilled and qualified identified.	The quality of the education and training to be delivered will be reviewed on a quarterly basis.
Ensure all key staff are able, encouraged and supported to attend training programmes around core principles of palliative and end of life care				• There is agreement across the organisations involved in the End of Life Care Partnership Group that training is a priority, and a commitment to ensure staff attend.	• ongoing

Adopt a system wide approach to the provision of palliative and end of life education. This should include all training providers across the island				• The education service to be implemented is available to all across the island without charge.	• ongoing
Extend membership of the Morbidity and Mortality Meetings to encourage island-wide attendance				• Not started	Once the Morbidity and Mortality meetings re-commence membership will be extended.
Outcome 6 - People in Jersey who need palliative and/or end of life care will be part of communities that talk about death and dying and that are ready, willing and able to provide the support needed					
Ensure everybody's voice is heard through this engagement				• Wide range of stakeholders at all stages.	• ongoing
Develop a proactive approach and plan to galvanise support and spread the message across our communities				• Not started	• Q4 2024 establish workstream
Develop An island-wide 'Carer Strategy' to ensure we address and meet the needs of these members of our community				• Not started	• Q4 2024 establish workstream
Undertake a carer assessment in order to establish need				• Not started	• Q4 2024 establish workstream
Combine all Third Sector elements to develop a robust, multifaceted model of care delivery which is supported by members of our community who are then reinforcing the need, spreading the message and having the conversations				• Working groups to design service developments have included third sector organisations.	• The development of a system wide care model is ongoing. • Communication plan to be developed and mobilised in 2025.

Health and Community Services

Jersey Hospice Care
your care, your choice, your time

A Palliative and End of Life Care Strategy for Adults in Jersey

2023-26

Government of Jersey

Citation

Title	**A Palliative and End of Life Care Strategy for Adults in Jersey 2023 – 2026**
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Published	October 2023
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Foreword

We are very pleased to present the Palliative and End of Life Care Strategy for Adults in Jersey 2023-2026. The strategy is essential in ensuring positive access to high quality care for all people and their families when approaching the end of their life. This Island-wide strategy is the result of a collaborative effort between Jersey Hospice Care, Jersey End of Life Care Partnership Group, Health and Community Services, and Public Health. Together, we have worked diligently to outline our vision, aims, objectives, and priorities that will guide our approach to palliative and end of life care over the next four years. By utilising evidence-based approaches, we aim to ensure that all individuals in Jersey will receive the highest quality of care and support during their end of life journey.

The overarching aim of this strategy is to enhance the quality of palliative and end of life care for adults in Jersey, regardless of their condition or care setting. To achieve this, we have set out specific objectives that include identifying local population needs and priorities, engaging with stakeholders, and agreeing on deliverables for the coming years.

While this strategy focuses on adult care provision, it is important to emphasise that our commitment to supporting Islanders extends from pre-birth to after death. To fulfil this commitment effectively, we must address the needs of individuals of all ages who are living with dying, death, and bereavement, as well as their families, carers and communities. Therefore, palliative and end of life care for children and young people will be the theme of a separate strategy document in the future.

This strategy acknowledges that palliative and end of life care is a continuum that encompasses the entire journey from the diagnosis of a life-limiting condition to death and bereavement. It provides a framework for delivering high-quality care, emphasising the importance of early identification of individuals in need of palliative care, the integration of palliative care with chronic condition management, and the development of skills necessary to anticipate and provide quality end of life care.

Furthermore, this strategy recognises and promotes the invaluable contribution of families and carers in providing informal care for their loved ones within our community. It highlights their role in interdisciplinary and interagency teamwork, which is central to delivering good quality palliative and end of life care.

The development of this strategy has been informed by a range of national and international strategies, as well as local initiatives undertaken in Jersey. Our aims are framed by the UK national framework that provides evidence-based principles translated into local action. Thus, this strategy provides a framework to support commissioners and care providers in achieving the desired outcomes outlined in the evidence-based framework Ambitions for End of life Care.

This palliative and end of life care strategy is built on a collective responsibility that involves all stakeholders. By highlighting this fact, we aim to increase awareness and recognition of the social responsibility we all share in providing help and being actively involved.

Looking ahead, we anticipate a significant increase in the demand for palliative care in Jersey, driven by projected population growth, a high prevalence of individuals aged 65 or older, and an increase of Islanders with co-morbidities. The numbers indicate a 50% increase in the need for palliative care by 2026 and nearly double the number of individuals requiring such care by 2036 compared to 2016.

We estimate that approximately 75% of the population in Jersey who passed away in 2021 could have benefited from generalist or specialist palliative and end of life care. These figures align with national and international trends, emphasizing the importance of our efforts in this area.

The desired outcomes of this strategy are clear. We must strive to ensure that people in Jersey who require palliative and end of life care are treated as individuals, encouraged to make and share advance care plans, and are involved in decisions regarding their care. They should receive timely recognition of their needs and conditions, ensuring fair access to services regardless of their background or characteristics. We aim to support them in living well for as long as possible, respecting their expressed wishes and maximising their comfort and wellbeing. Care should be well-coordinated, provided by well-trained individuals who continually update their skills and competencies. Ultimately, we seek to foster communities that openly discuss death and dying, prepared and willing to provide the necessary support.

To achieve these outcomes, we have identified four essential enablers: active engagement with the public and patients, the use of technology to inform and improve care, education and workforce development, and the co-design of an island-wide integrated model of palliative and end of life care.

We extend our deepest gratitude to the Jersey End of Life Care Partnership Group, patients, carers, and those involved in the development of this strategy. With your support and commitment, we can make a profound difference to the lives of individuals and families during their most vulnerable moments. Together, let us strive to provide compassionate and person-centred palliative and end of life care that truly meets the needs of our community, ensuring every individual's journey meets their individual choices and is filled with dignity, comfort, and care of the highest quality.

Karen Wilson
Minister of Health and Social Services

Mike Palfreman
Chief Executive – Jersey Hospice Care

Acknowledgement

I would like to take the opportunity to formally thank all those who have participated in the development of this Palliative and End of Life Care Strategy 2023-2026 for Jersey.

The voice of the patient and carers has been an essential element throughout this document, and thanks go to all those who devoted their time to inform us as to what services work well, where the gaps are and the needs going forwards.

Palliative and end of life care impacts all areas of health care and as such the End of Life Care Partnership Group has worked together to ensure we develop a plan to improve care and services for patients and their families.

In addition, I would like to thank all my colleagues across Jersey Hospice Care, HCS Commissioning and Public Health teams, particularly my co-authors, who have all worked together to bring this strategy to publication, reinforcing that `Together we are stronger`.

Finally, I give special thanks to my family for their continuous support and understanding during the long hours spent developing this Strategy.

Gail Caddell
Director of Clinical Strategy – Jersey Hospice Care

Contents

Introduction

This Island-wide strategy sets out the vision, aims, objectives and priorities that will help Jersey respond to local priorities over the next four years using evidence-based approaches to care and support.

Palliative care should be strongly responsive to the needs, preferences and values of people, their families and carers, 24 hours per day, 7 days per week.

A person and family-centred approach to palliative care is based on effective communication, shared decision-making and personal autonomy. Palliative care should be available to all people living with an active, progressive, advanced disease, regardless of the diagnosis.

Palliative care affirms life while recognising that dying is an inevitable part of life. This means that palliative care is provided during the time that the person is living with a life-limiting illness, but it is not directed at either bringing forward or delaying death.

Dr Ros Taylor (National Director for Hospice Care, Hospice UK) outlined the key challenges that palliative care providers face as (1):

- Response to a dramatically escalating demand for palliative and end of life care
- Adaptation to meet the needs of an ageing population living with and dying from chronic illnesses and multiple co-morbidities where longevity is frequently compromised by frailty, disability and dependence
- Ability to deliver equitable, quality care to those who need it in an environment of financial constraint

Furthermore, Dr Taylor cites that these challenges are contextualised today where personal autonomy is paramount as people are increasingly expressing the importance of choice and independence as major components of dignity in advancing illness and old age. This supports people's expectations to make decisions, not only on how we live the last years, months, weeks and days of life but also on how and where we die.

She is clear that to meet the needs of the future, palliative care providers must be prepared to do things differently.

Whilst this strategy relates specifically to adult care provision, as a community, we aim to support Islanders from pre-birth until after death. To do this well, the needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, considering their priorities, preference and wishes. Palliative and end of life care for children and young people will be the theme of a separate strategy document in the future.

The strategy recognises that palliative and end of life care forms a continuum of care that may apply from diagnosis of a life limiting condition, right through to death and bereavement. Within this context, the Strategy provides a framework for high quality palliative and end of life care, emphasising the significance of early identification of an individual's need for palliative care, the interplay between palliative care and chronic condition management and the importance of ensuring that the skills are in place to anticipate and deliver quality end of life care.

In addition, the strategy recognises the significant contribution within communities which families and carers make in providing informal care for their loved ones. It promotes their role in the interdisciplinary and interagency teamwork that is central to good quality palliative and end of life care.

It is known from national (2) and local evidence that as a community, when we or our loved ones approach the end of our lives we want to:

- Have choice about where we want to receive care
- Be involved in decisions about our care
- Be treated with dignity, respect and to be heard
- Have access to support when we need it
- Be cared for by professionals who are well trained to deliver palliative and end of life care
- Know that our loved ones will be supported

Palliative and end of life care has been very topical in the media recently as discussions have taken place in Jersey around “Assisted Dying” which is due to be fully debated in Government 2023 following a vote after the recommendations of the Citizen’s Jury. If assisted dying is to be an option, it is crucial that we ensure there are robust palliative care services across Jersey, so islanders have a real choice around end of life decisions and are not pushed into making any decision based on lack of alternative services. There have been robust discussions between Policy and Clinical Palliative Care leads, and all parties are adamant that this is an essential component in taking the Assisted Dying Bill forward.

Palliative and End of Life Care Definition

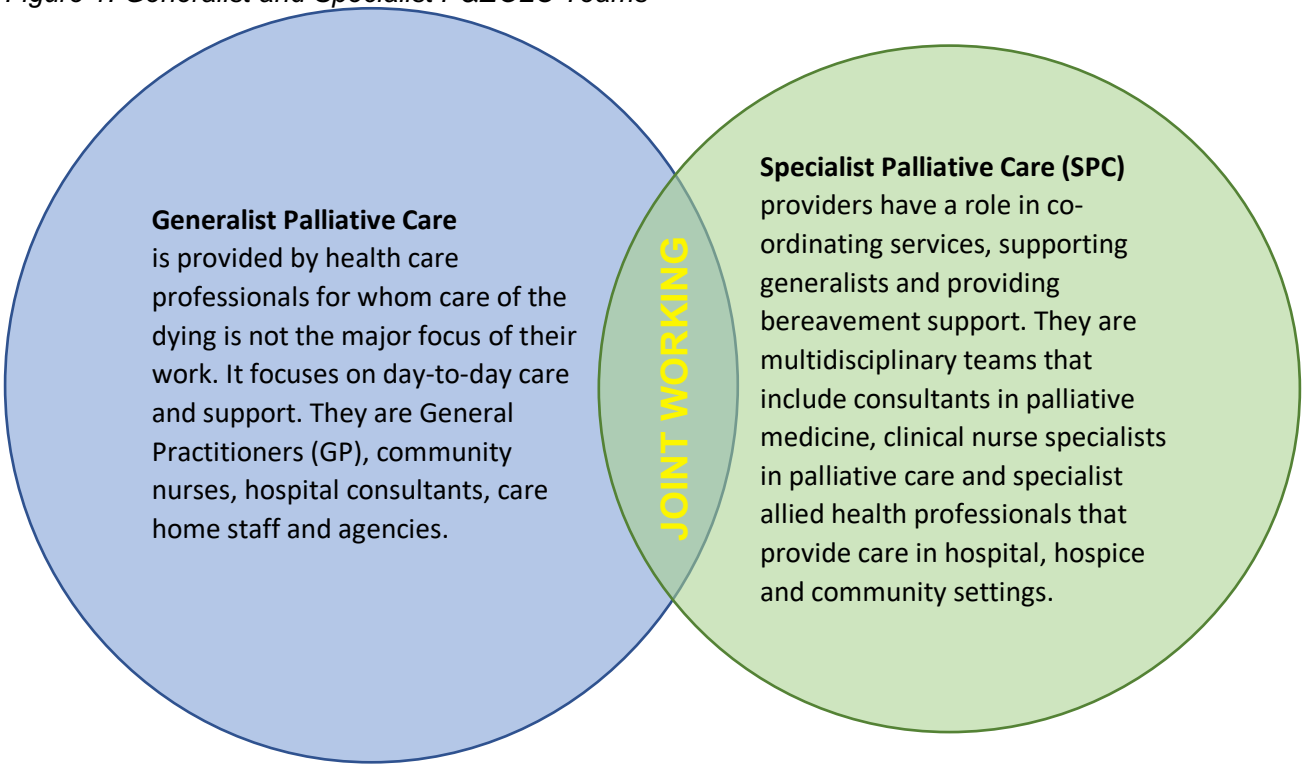
According to the World Health Organisation (WHO), palliative care is “an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual” (3). The NHS defines end of life care as a form of palliative care that can be received in the final year of life (4).

Palliative, supportive and end of life care aims to provide the best possible quality of life for people with life-limiting or life-threatening illnesses who are approaching the end of life. It is evidence based, holistic and improves not only patients’ experience of their care, but also the experiences of their families and loved ones at the most difficult of times. In addition, palliative care contributes towards the cost-effective functioning of the health and social care system, enabling greater patient choice where it is available. Such support is needed in all places where people are cared for by managing symptoms to ensure people are supported in having the best quality of life possible whether home, community, hospital, hospice or care home.

Furthermore, as discussed within the Prague Charter developed by the European Association for Palliative Care, palliative care is a recognised component of the right to the highest attainable standard of health, which is protected in article 12 of the International Covenant on Economic, Social and Cultural Rights, and in article 24 of the Convention on the Rights of the Child (5).

Most people living with a life-limiting illness will require generalist or specialist palliative and end of life care (P&EOLC) (6). The interface between these two teams demonstrates the joint working that is essential for care around the patient and the family. The distinctions between these services can be seen in Figure 1.

Figure 1. Generalist and Specialist P&EOLC Teams



The care delivered by these providers also presents its intricacies (7):

Generalist and Core Level Palliative Care Provision: All professionals and staff in health and social care have a role in the effective provision of palliative and end of life care services across all care settings. The Specialist Level Palliative Care multidisciplinary team (SLPC MDT) are expected to proactively support, advise, assist and guide education and training to these staff.

Professionals and staff working in services providing core level palliative and end of life care make an important contribution and may be specialists in other disciplines and services; however, unless they are led by a SLPC MDT they cannot be considered to provide a specialist level palliative care service.

Specialist Level Palliative Care Services: Specialist level palliative care is required by people with progressive life-limiting illness, with or without co-morbidities, where the focus of care is on quality of life and who have unresolved complex needs that cannot be met by the capability of their current care team. These needs may be physical, psychological, social and/or spiritual. Examples include complex symptoms, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions.

Specialist level palliative care is delivered by a multidisciplinary team (MDT) of staff with the requisite qualifications, expertise and experience in offering care for this group of people, to support them to live as well as possible during their illness ensuring their comfort and dignity are maintained as they come to the end of their lives. Input from specialist level palliative care professionals to the care of a person must be based on the needs of the person and not the illness they have.

Vision, Aim and Objectives

Vision

The vision of this strategy is to ensure that all Islanders with a life-limiting illness will have access and informed choice to the right care, by the right person, at the right time and in the right place.

Aim

The overall aim of this strategy is to improve the quantity and quality of palliative and end of life care for adults (over the age of 18) in Jersey irrespective of condition or care setting by:

1. Providing the foundations for a policy and commissioning framework which will enable the development of an integrated pathway through which public, independent, community and voluntary care providers can deliver high quality palliative and end of life care to the people of Jersey.

2. Ensuring that palliative and end of life care is focussed on the person rather than the disease and that the principles and practices of high-quality care are applied without exception to all who need it.

Objectives

The strategy objectives are:

1. Identifying patients in need of palliative and end of life care earlier

2. Increasing the involvement of palliative and end of life care patients in decisions regarding their care

3. Improving the access and quality of the support provided to palliative and end of life patients, families and carers

4. Maximising the comfort and wellbeing of palliative and end of life patients to live well as long as possible

5. Improving patients', families' and carers' experience

6. Increasing willingness and ability of the community to support people who need palliative and end of life care, their families and carers

7. Strengthening the palliative and end of life services in Jersey

8. Optimising cooperation, coordination and collaboration across different organisations in Jersey

In order to design the objectives, the following steps were taken:

1. Establish an end of life partnership group

2. Establish a working group

3. Identify local population needs and priorities

4. Engage with all stakeholders

5. Agree deliverables for 2023-2026

6. Provide a framework to support commissioners and providers in achieving the outcomes identified in the national evidence-based framework Ambitions for End of Life Care

Evidence to Support the Need for an End of Life Care Strategy

Global Picture

Each year, an estimated 56.8 million people, including 25.7 million in the last year of life, are in need of palliative care (8).

In the UK there were approximately 600,000 deaths in 2021, of which around 75% (450,000) were expected deaths that could have benefited from palliative care (9). Approximately 200,000 people in the UK die each year with palliative care needs that are not met (10).

It is recognised that the UK's population is ageing and it is estimated that by 2050, one in four people will be aged 65 years or over (11). In England and Wales it is projected that, by 2040, the number of people requiring palliative care will grow by 25% to 42% due to complex multiple long term health conditions, dementia and cancer being the main drivers of increasing need (12).

Predisposing Causes

According to the World Health Organization, the majority of adults in need of palliative care have chronic diseases such as cardiovascular diseases (38.5%), cancer (34%), chronic respiratory diseases (10.3%), AIDS (5.7%) and diabetes (4.6%) (3). Furthermore, research has shown that the conditions recognised as needing palliative care are (13):

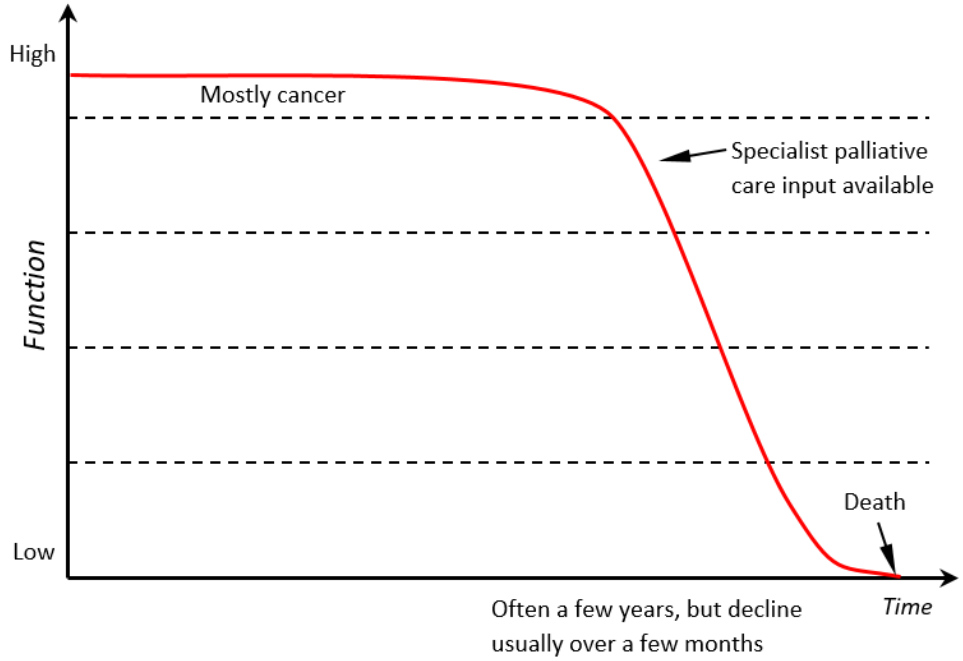
- Cancer
- Heart disease, including heart failure
- Cerebrovascular disease (stroke)
- Renal disease (chronic renal failure)
- Liver disease
- Respiratory disease (chronic respiratory disease and respiratory failure)
- Neurodegenerative diseases
- Dementia, Alzheimer's disease, and senility
- HIV AIDS

Illness Trajectories

There is good evidence that integrating palliative care with disease-modifying therapies improves symptom control, quality of life, and family satisfaction. Moreover, early access to palliative care can reduce the provision of clinically non-beneficial therapies, prolong life in some populations, improve the quality of life of people with a life-limiting illness, and significantly reduce hospital costs (14), (15).

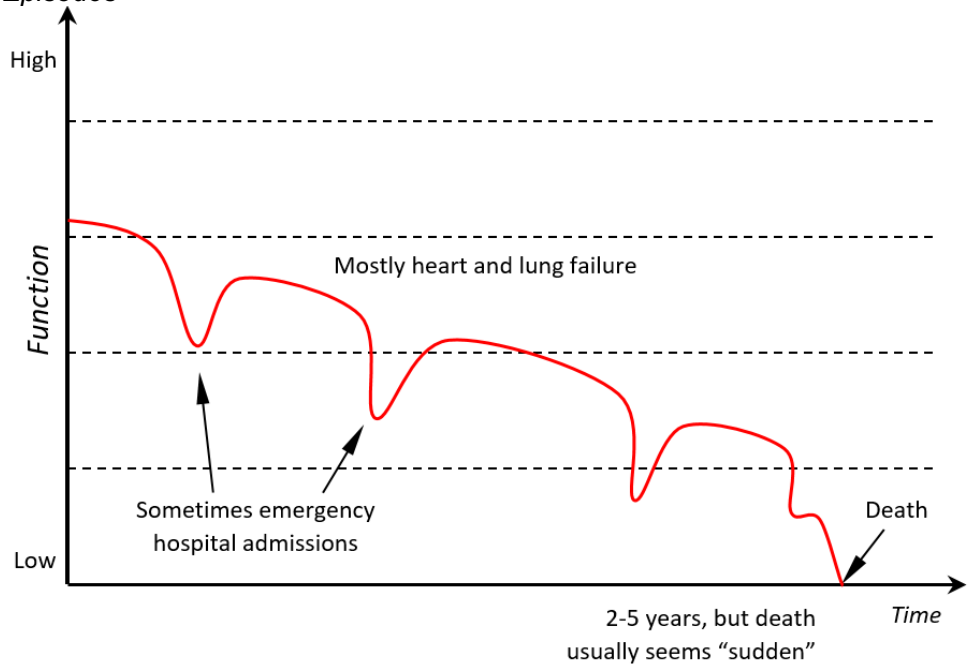
Planning should also be informed by an understanding of typical illness trajectories among people dying an expected death (16) as shown in Figure 2, Figure 3 and Figure 4:

Figure 2. Illness Trajectory for Patients with Short Period of Evident Decline



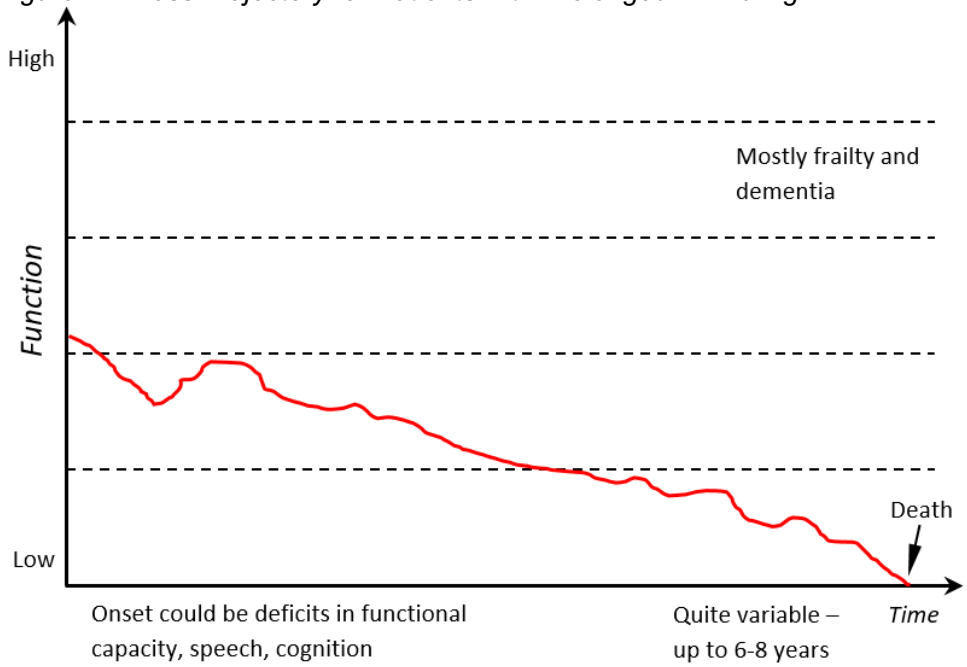
There is long maintenance of good function which may be followed by a few weeks or months of rapid decline prior to death. Most reduction in function occurs in the person's last few months of life.

Figure 3. Illness Trajectory for Patients with Long-term Limitations with Intermittent Serious Episodes



There is a gradual decline in function, interrupted by episodes of acute deterioration. While there is a risk of dying during each of these acute episodes the person may survive but will continue to decline in function. The time of death usually remains uncertain.

Figure 4. Illness Trajectory for Patients with Prolonged Dwindling



There is long-term, progressive disability and reduction in function. Death may follow other events such as infections, falls and fractures.

Based on typical illness trajectories Jersey has proposed a model that conceptualises the population of people living with a life-limiting illness as falling within three broad groups outlined in the graphs above based on the complexity of their needs for palliative care, as follows:

People with straightforward and predictable needs - this group comprises people whose needs are generally able to be managed through their own resources (including with the support of family, friends and carers) and/or with the provision of palliative care by their existing health care providers (including GPs, community nurses, geriatricians, oncologists and other health professionals). People in this group do not usually require care delivered by specialist palliative care providers.

People with intermediate and fluctuating needs - this group includes people who experience intermittent onset of worsening symptoms (such as unmanaged pain, psychological distress and reduced functional independence) that might result in unplanned and emergency use of hospital and other health services. People in this group may require access to specialist palliative care services for consultation and advice. They will also continue to receive care from their existing health care providers.

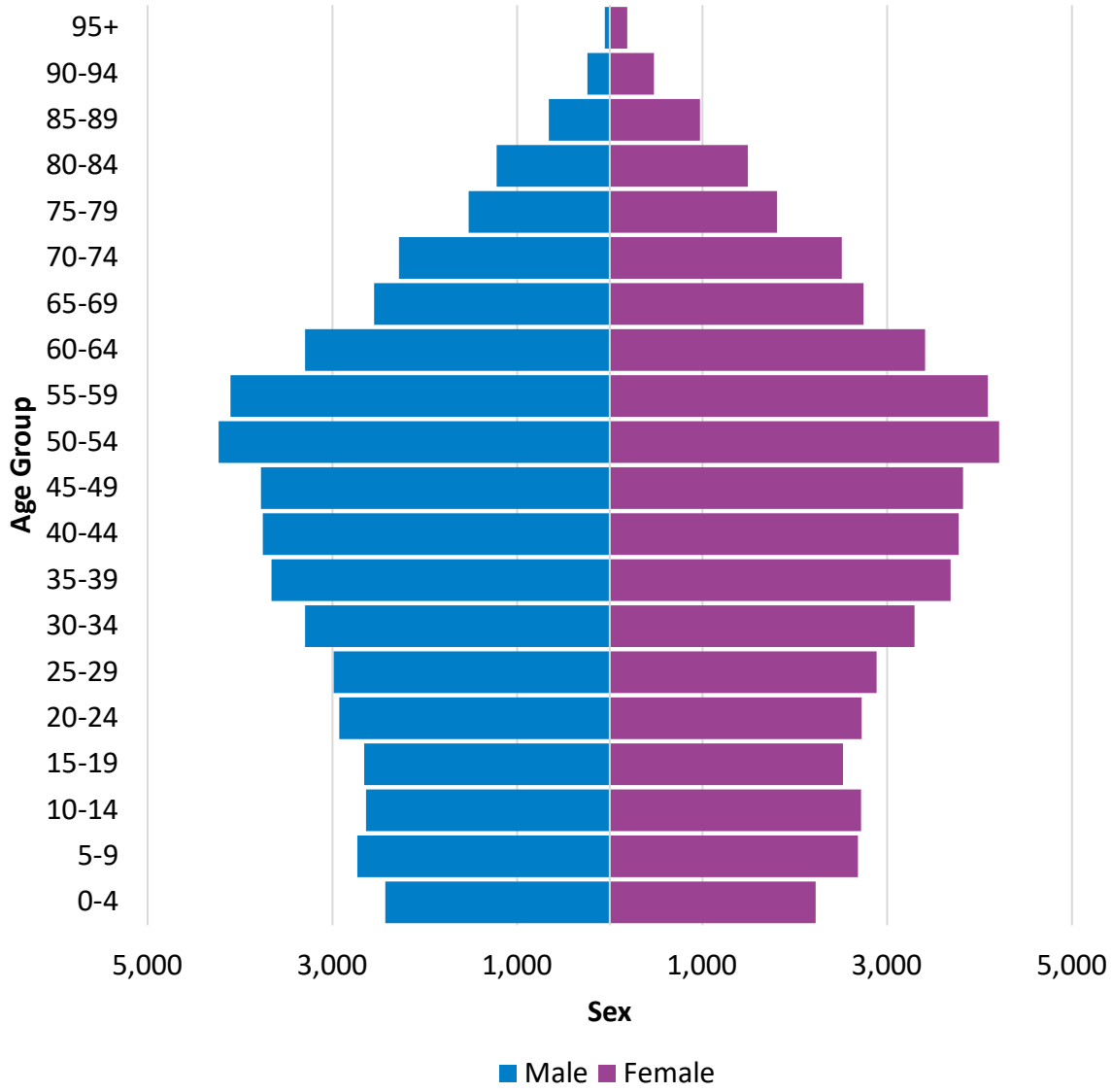
People with complex and persistent needs - this group comprises people with complex physical, psychological, social and spiritual needs that are not able to be effectively managed through established protocols of care. While people in this group will require more ongoing direct care by Specialist palliative care providers, this should occur through partnerships and shared care models with existing health care providers.

Statistics

Demographics

The 2021 census found that the population of Jersey on 21st March 2021 was 103,267. It consisted of 52,264 females and 51,003 males and was characterised by more people in their middle age than in the other age groups. Figure 5 shows how Jersey's population is distributed across age groups and genders.

Figure 5. Population Structure of Jersey 2021 (17)



In 2021 the greatest proportion of people by age were those in their fifties. Around 18% of the population were aged over 65 which represents an increase since 2011 when it was 15% and is consistent with an overall ageing of the population over the last decade (18).

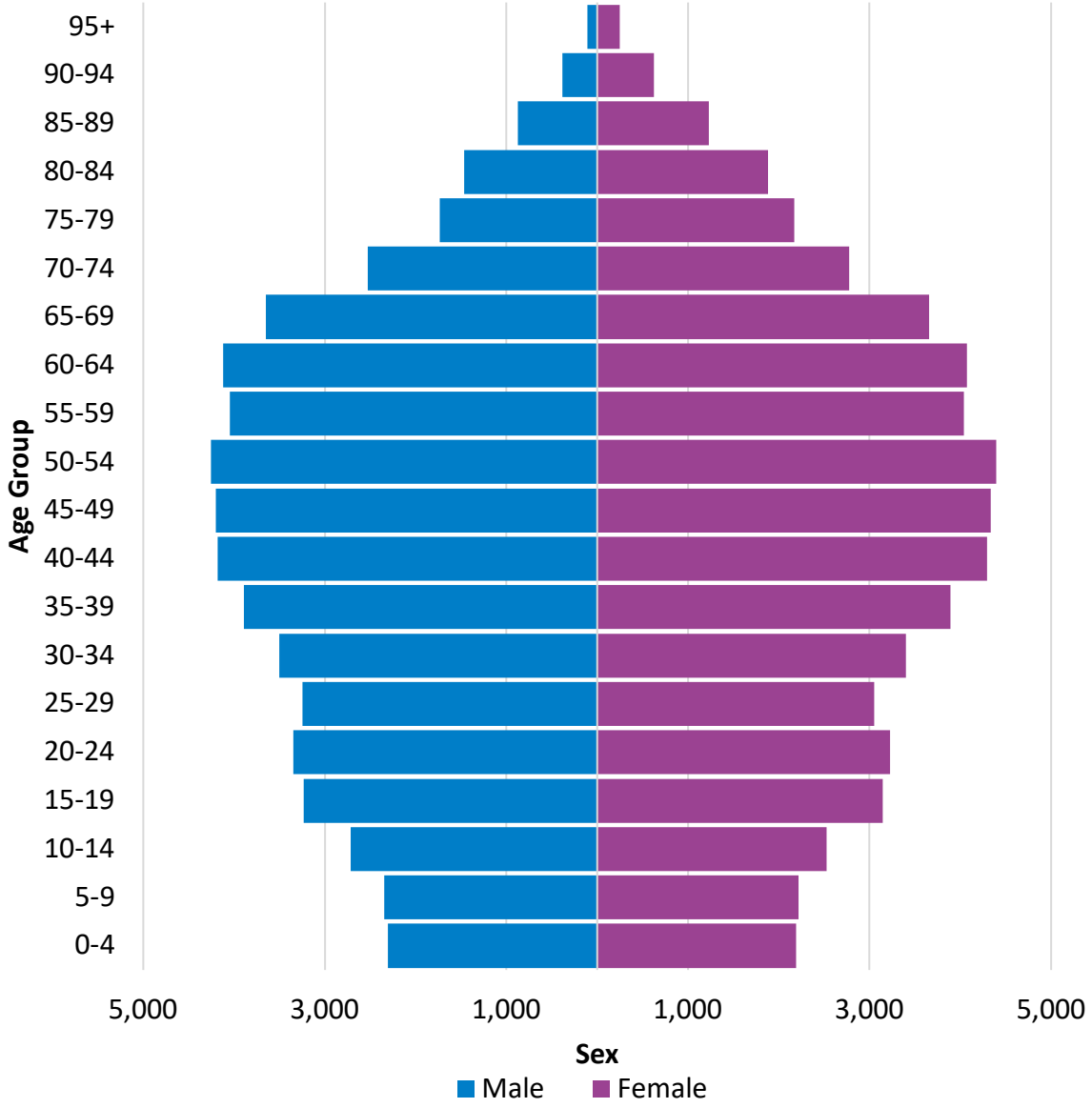
As the 2016 Jersey Health Profile (19) highlighted, it is therefore important to consider the accumulation of morbidities in these individuals as they age since health issues tend to

accumulate over time, and individuals who are 65 years or older typically experience poorer health outcomes compared to those who are younger (19).

Population Projections

In 2032, the projected population is 113,498, an overall increase of 9%. The proportion of those aged 65 or over is projected to increase from around 16% in 2016 to 22% in 2032 (Figure 6).

Figure 6. Population Pyramid, as at 1 January 2032 Assuming 1,000 Net in Migration per Annum (20)



By 2036, the population is projected to increase by another 11 per cent, to 130,000, under the +1,000 net migration scenario. Around one in five of the population would be aged 65 or over. Having a larger population of those aged 65 or over has implications for the health service, especially if these individuals have accumulated morbidities over their lifetime.

Projected Numbers of Population with Palliative Care

Given the prediction that Jersey's population will increase, with higher prevalence of those aged 65 or older and with a higher number of co-morbidities, it is not surprising that there is a projected 50% increase of people needing palliative care in 2026 and almost twice the number of people needing palliative care by 2036, compared to 2016. This represents an increase of around 400 patients as shown in Table 1.

Table 1. Projected Numbers of Males and Females with Palliative Care needs by Age in Jersey Between 2016 and 2036 (20)

	2016	2026	2036
Projected population with Palliative Care Needs in Jersey	400	600	800
Projected percentage variation from 2016		+50%	+100%

Advance Care Plan

During a limited study of Gold Standards Framework (GSF) Red patients undertaken in 2021, it was found that an average of 53% of Hospice patients had had an Advance Care Plan discussion.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Data from Jersey General Hospital show that approximately 1,000 DNACPR forms are completed every year and 2022 has seen a total of 979. Furthermore, 11 GP practices had a total number of 553 DNACPR forms in 2021.

Age-Standardised Mortality Rate in Jersey 2021

The age-standardised mortality rate is a measure of the overall mortality in a population, adjusted for differences in age distribution. The age-standardised mortality rate is expressed as the number of deaths per 100,000 people and is used to compare mortality rates between populations with different age and sex distributions.

Comparison with England shows that Jersey had a lower overall age-standardised mortality rate, and both lower male and female age-standardised mortality rate than all the English regions as seen in Table 2.

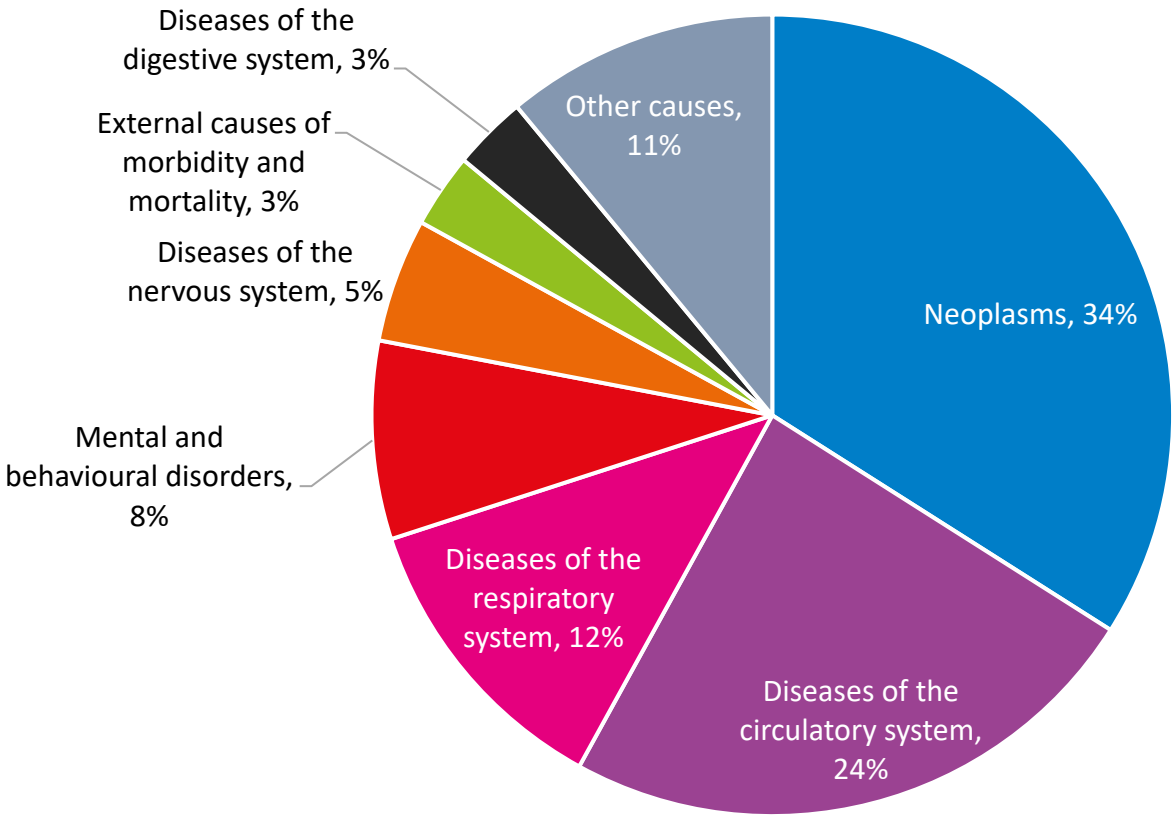
Table 2. Age-Standardised Mortality Rates per 100,000 Population, by Sex, for Jersey, England and UK Nations 2021 (21)

	Males	Females	Persons
Jersey	871	667	759
England	1,153	844	985
Wales	1,235	917	1,062
Scotland	1,375	1,024	1,181

Cause of Death

Figure 7 details the main causes of death in Jersey in 2021 where neoplasms account for 34% of all deaths, making it the lead cause (18). Diseases of the circulatory system are responsible for 24% of deaths, while diseases of the respiratory system account for 12%. Mental health and behavioural disorders contribute to 8% of all deaths, and diseases of the nervous system are responsible for 5% of deaths. External causes of morbidity and mortality, such as accidents and injuries, represent 3% of deaths, while diseases of the digestive system account for another 3%. The remaining 11% of deaths are caused by other factors. This highlights the need for effective end of life care strategies that address the specific needs of individuals with different illnesses and conditions.

Figure 7. Main Causes of Death in Jersey in 2021 (18)



Non-sudden Deaths

Considering Figure 7, the leading causes of death in Jersey are neoplasms (cancer), diseases of the circulatory system (heart disease and stroke), and diseases of the respiratory system (chronic obstructive pulmonary disease and pneumonia). These diseases, along with diseases of the nervous system, are all considered to be life-limiting, meaning that they can cause death within a relatively short period of time and therefore be considered as non-sudden deaths. Considering that most people living with this spectrum of diseases would require palliative and end of life care, 75% of the population of Jersey that died in 2021 would have benefitted from generalist or specialist palliative and end of life care. This estimation is in line with the numbers from England and Wales that also evaluate that 75% of people would benefit from palliative care as they approach the end of life (22).

Preferred Place of Care and Preferred Place of Death

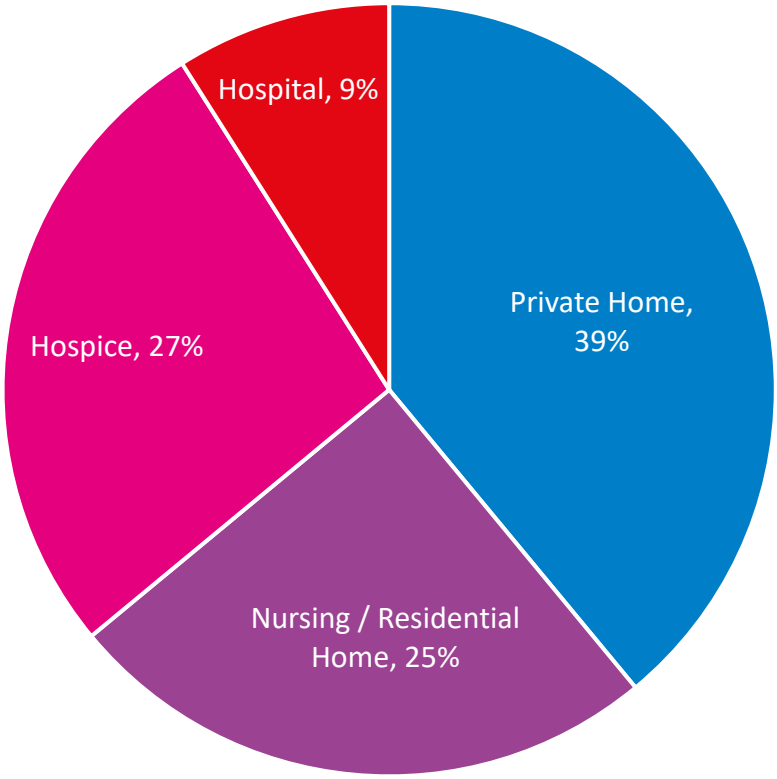
End of life care can be provided in a variety of settings depending on individual needs and preferences. However, it tends to be provided at home, in a care home, in a hospice or in hospital (4).

The preferred place of care is a person's choice of where they would like to receive end of life care and eventually die. The preferred place of care can have a significant impact on the person's quality of life and their sense of comfort and dignity. People who are dying often have strong preferences about where they would like to receive care.

People in Jersey who are under the Specialist Palliative Care Team, have their preferred place of care and preferred place of death recorded as part of their advance care plan. The preferred place of care was achieved for 79% of those.

In relation to the preferred place of death, the majority of Islanders under Specialist Palliative Care wish to die at home (39%), followed by hospice (27%) and nursing or residential home (25%) and only 9% expressed their desire to die in hospital.

Figure 8. Preferred Place of Death of Patients in Jersey under the Specialist Palliative Care Team in 2021

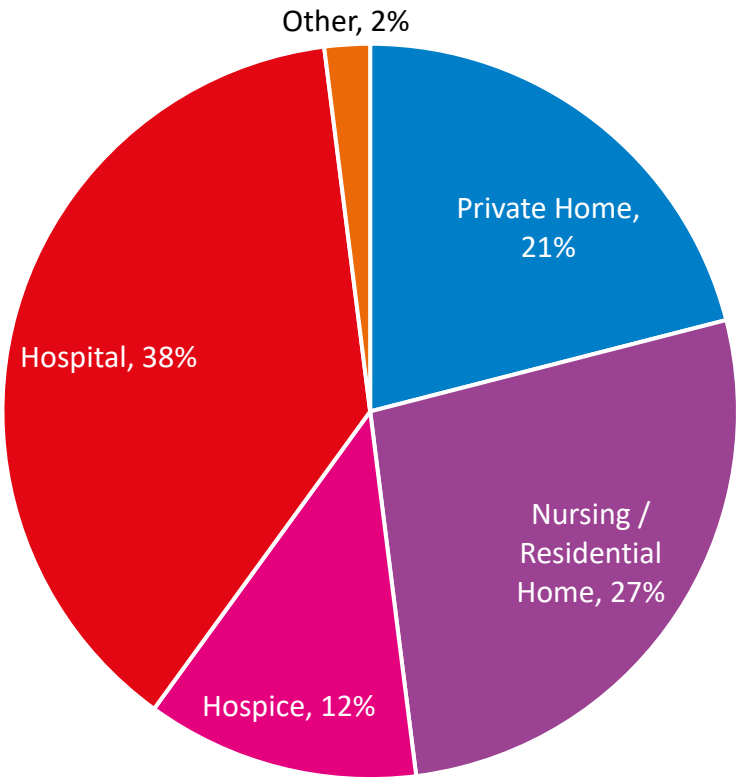


Location of On-Island Deaths

Contrary to the above, and despite the need to take into account that these numbers include sudden deaths, in 2021 in Jersey, the highest proportion of deaths (38%) occurred in hospital followed by nursing and residential home (27%). One in five died in a private home and one in eight died in Jersey Hospice.

Nonetheless, the proportion of deaths of Jersey residents occurring on-island which took place in the hospital has decreased over recent years, from one in two (50%) to under two in five (38%).

Figure 9. Location of On-Island Deaths in Jersey 2021 (21)



In 2021 in Jersey, the highest proportion of deaths (38%) occurred in hospital; one in five died in a private home (21%); one in eight in Jersey Hospice (12%) and approximately one in four in a nursing home or a placement for residential or personal care (8%).

However, figures show a different scenario when people are under specialist palliative care in Jersey as shown in Figure 10. There is a small reduction of people dying in hospital (35%) and Nursing or Residential Homes (20%) and more people die in hospice (25%). There is no significant change for the proportion of people that die in their own private home.

Figure 10. Location of Deaths under Specialist Palliative Care in Jersey in 2021

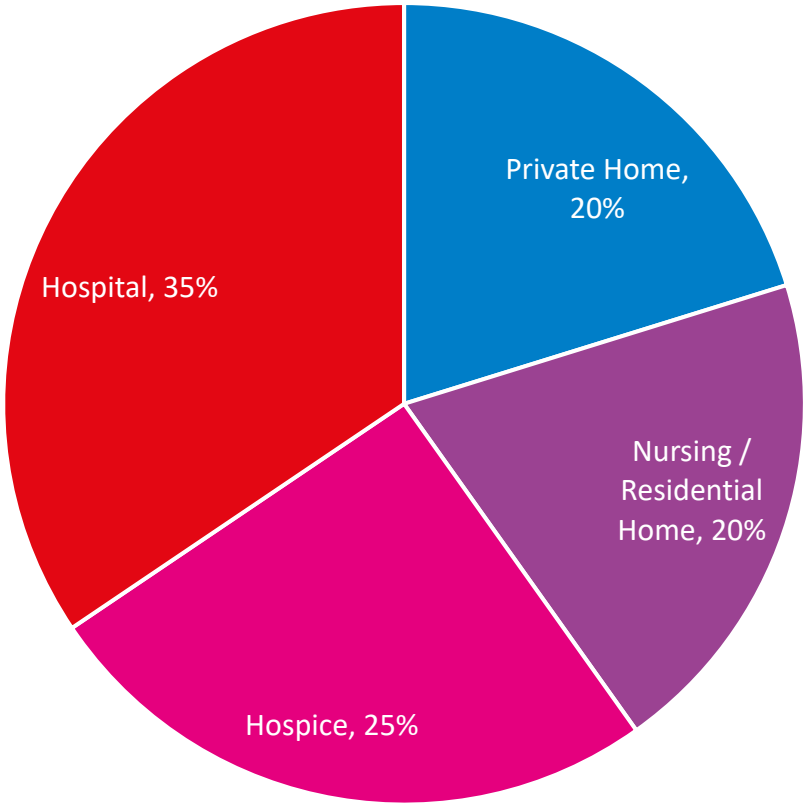
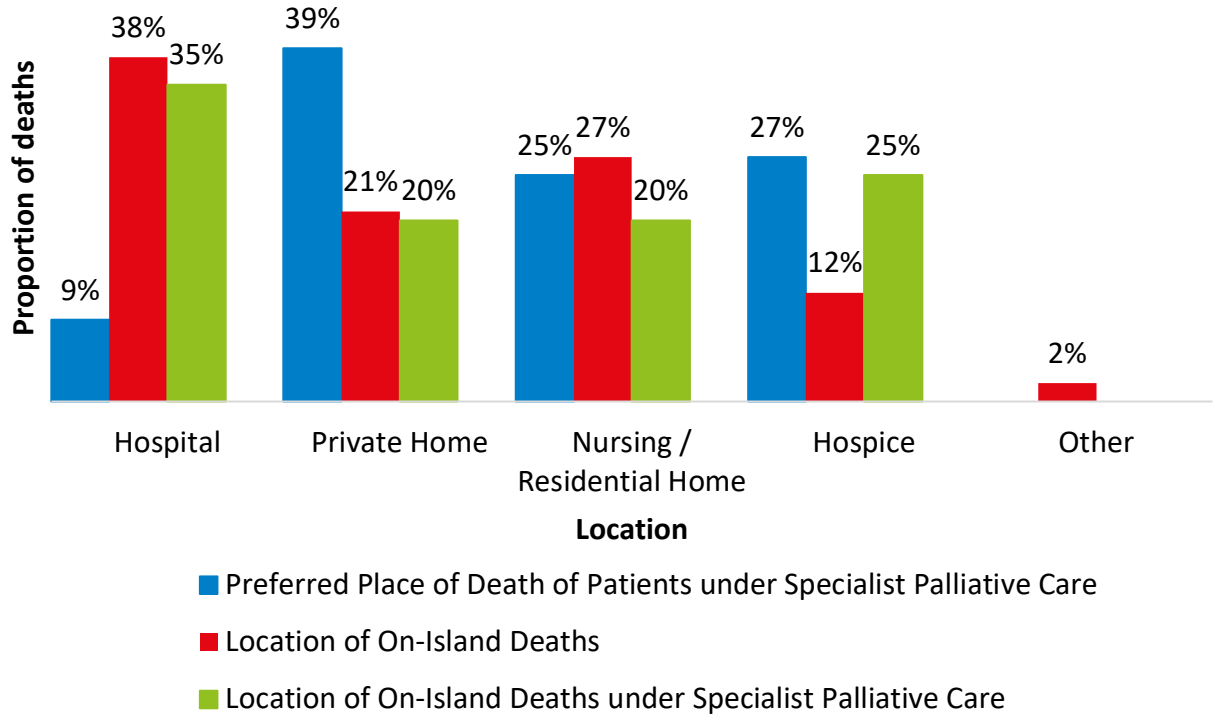


Figure 11 compares the three charts above about preferred place of death with the actual location of on-island deaths in Jersey whether the person was under specialist palliative care or not, broken down by location.

Figure 11. Comparison of Preferred Place of Death of Patients under Specialist Palliative Care with Location of On-Island Deaths and Location of On-Island Deaths under Specialist Palliative Care in 2021



As observable, there are significant differences between the preferred place of death and the actual location of on-island deaths in Jersey. For example, 39% of people would prefer to die in their own private home, yet only 21% of deaths in Jersey occur there. Hospice is the preferred place of death for 27% of people, but only 12% of deaths in Jersey occur in hospice. This suggests that more needs to be done to support people to die in their preferred location, particularly in their own homes or in Hospice.

In England (23), information shows that 44% of people die in hospital followed by 29% in private home, 20% in nursing or residential home and only 3% in hospice. However, it is important to note that the two locations have different healthcare systems and cultural attitudes towards end of life care, which may account for some of these differences.

Furthermore, when looking at the data for those under specialist palliative care, there are some differences compared to the overall figures. For example, a higher proportion of people die in hospice (25%) than in the general population, indicating that specialist palliative care services are better able to support people to die in their preferred location.

It is also worth noting that for people under specialist palliative care in Jersey, the preferred place of death is split almost equally between their private home (20%) and hospice (25%), rather than being predominantly in a hospice as might be expected. However, the actual location of on-island deaths for people under specialist palliative care in Jersey is still predominantly in hospitals (35%) with only 20% occurring in private homes and 20% in nursing or residential homes. This suggests that there may be need for increased support and resources for people under specialist palliative care to help them die in their preferred location, whether that be at home or in a hospice, even though 85% of those patients died in their preferred place in 2021.

Referrals to Jersey Hospice Care

Jersey Hospice Care provides a variety of end of life services to Islanders. These include the Palliative Care Inpatient Unit, Specialist Palliative Care Team and Day Hospice and also Therapies and Bereavement & Emotional Support to the general Jersey population that have lost their loved one. Analysing the referrals to these services will provide insights into its utilisation and the trends in referrals over the years. Understanding these referral patterns is crucial for developing an effective end of life care strategy for the community.

Figure 12. Annual referrals to Jersey Hospice Care by Service Between 2016 and 2022

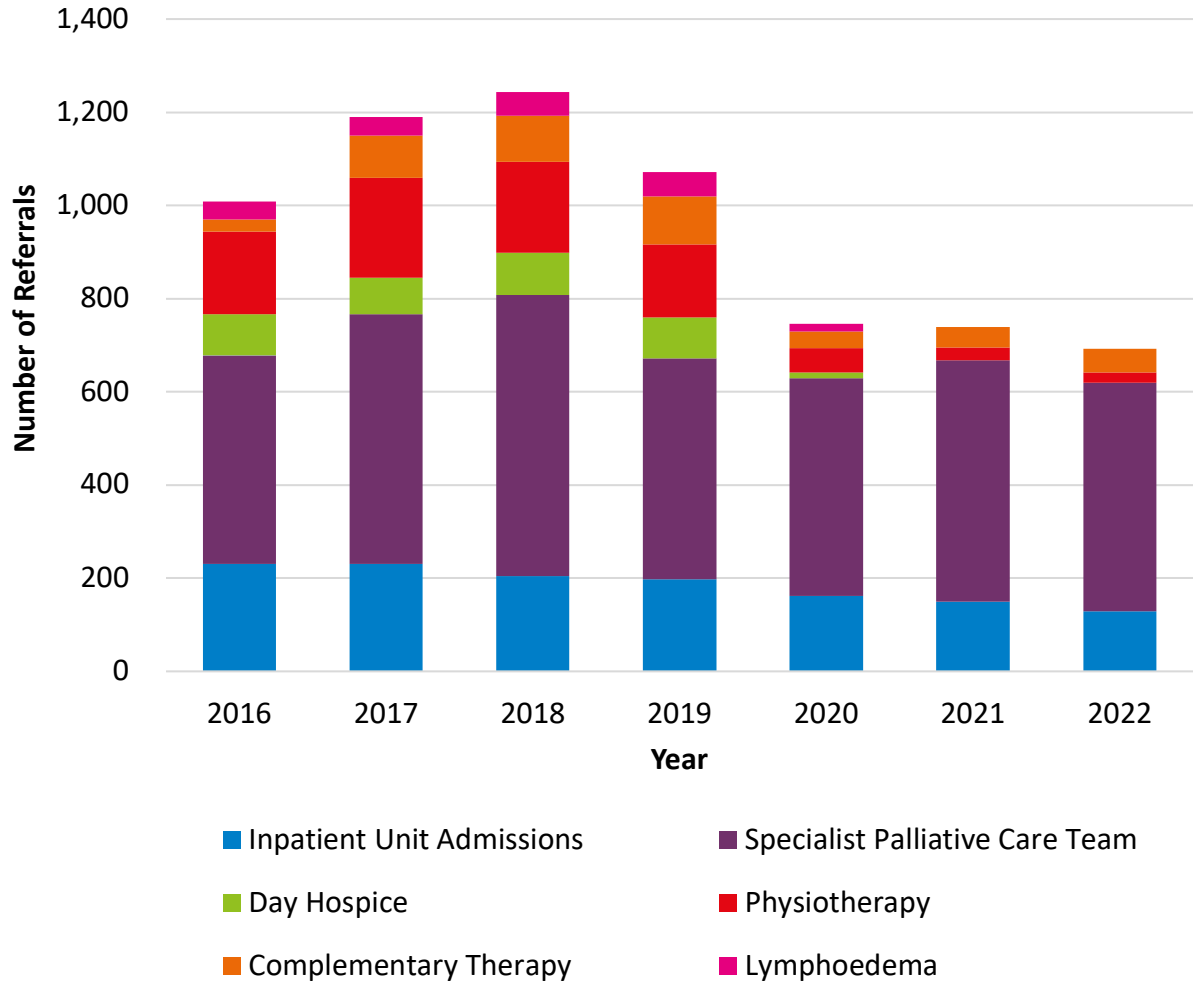
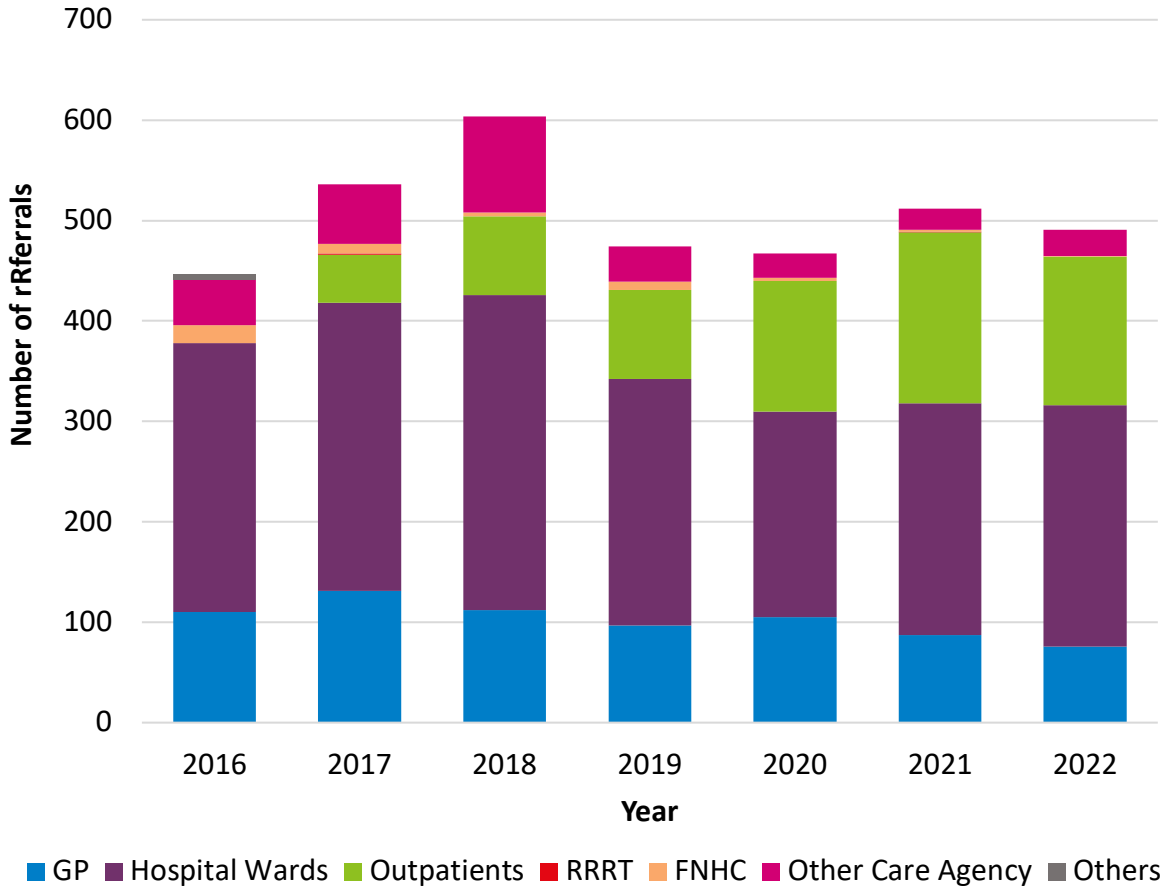


Figure 12 emphasises the significance of inpatient care and indispensable role of the Specialist Palliative Care Team in managing complex medical conditions and symptoms. It is important to note that the Bereavement and Emotional Support service wasn't available between 2016 and 2019 and both Day Hospice and Lymphoedema services were closed in 2021 at the outset of COVID.

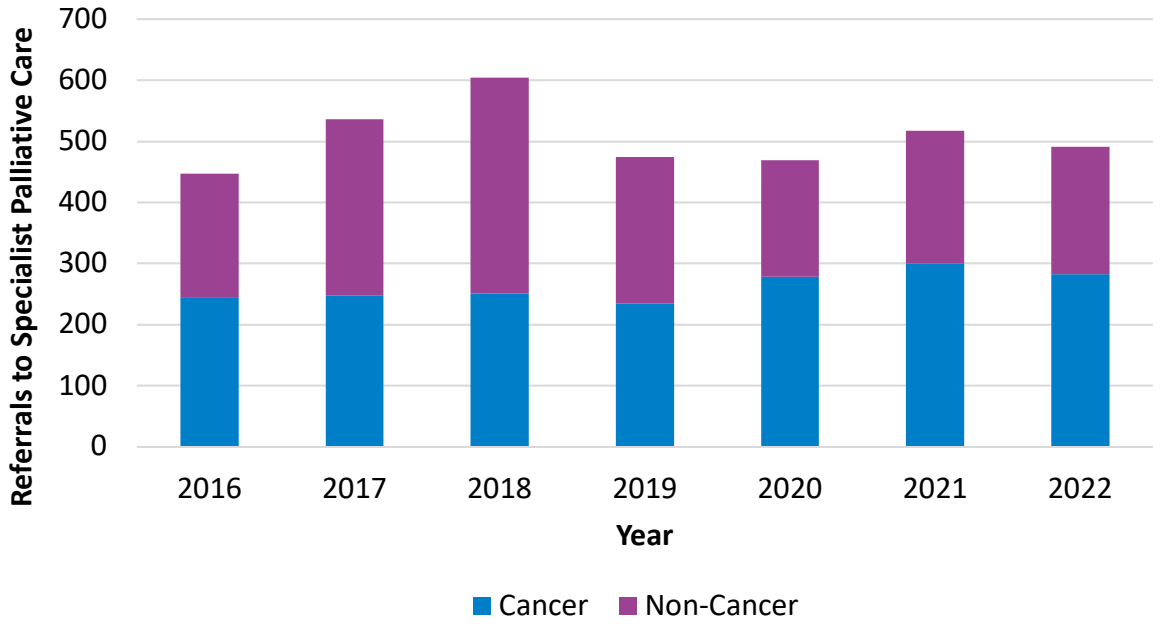
Figure 13. Number and Origin of Referrals to SPC in Jersey from 2016 to 2022



By understanding the source of the referrals to Specialist Palliative Care, providers can work with other healthcare professionals and the general public to ensure that people who need palliative care are able to access it. As Figure 13 shows, since 2016 most referrals come from hospital wards, GPs and outpatients. The outpatient referrals have gradually gained more emphasis over the years making it the second leading source from 2020 onwards. This might suggest there is a growing awareness and recognition of the importance of palliative and end of life care among healthcare professionals as well as an increasing prevalence of chronic illnesses.

Furthermore, by making the distinction between cancer and non-cancer patients referred to SPC (Figure 14), care providers can ensure that they are meeting the specific needs of both groups of patients and all patients that need palliative care are able to access it.

Figure 14. Annual Cancer and Non-Cancer Referrals to SPC in Jersey Between 2016 and 2022

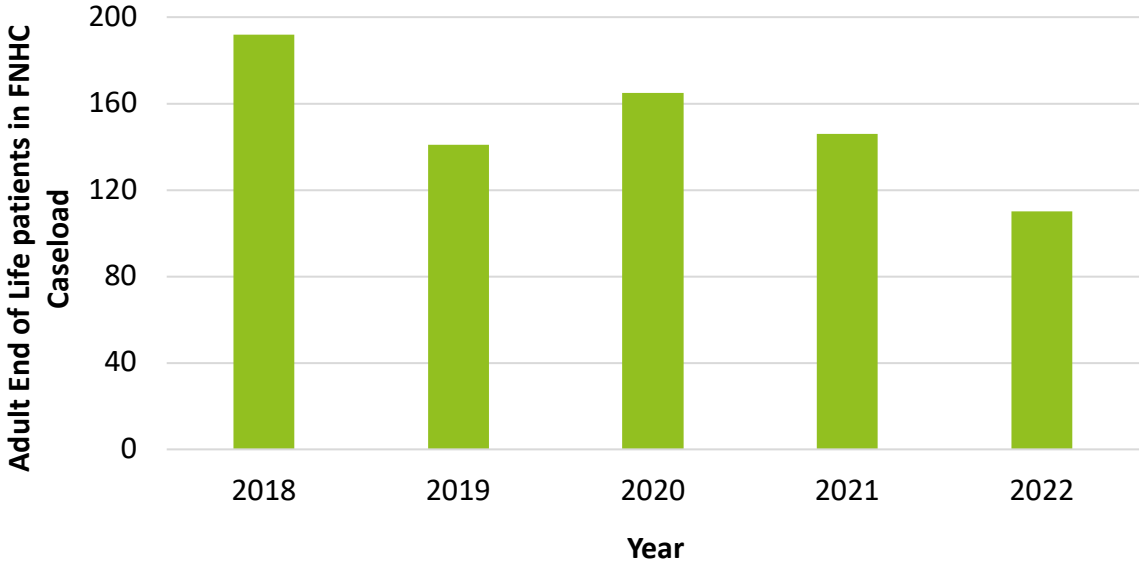


This data shows that until 2018, and before the COVID-19 pandemic, patients without cancer but with other life-limiting illnesses referrals were increasing, going down to levels similar to 2016 in 2020 and remained relatively static until last year. This highlights the importance of both cancer and non-cancer patients having access to specialist palliative care by reducing barriers, expanding the availability of palliative care services, improving communication and coordination of care and increasing awareness.

Referrals to Family Nursing and Home Care for Palliative Care

Family Nursing and Home Care (FNHC) is an important provider of generalist palliative care in the community both through District Nurses and the Rapid Response and Reablement Team (RRRT). Figure 15 shows the adult caseload in FNHC for District Nurses and the Rapid Response and Reablement Team from 2018 to 2022 that had one of the palliative or end of life care codes added to their record.

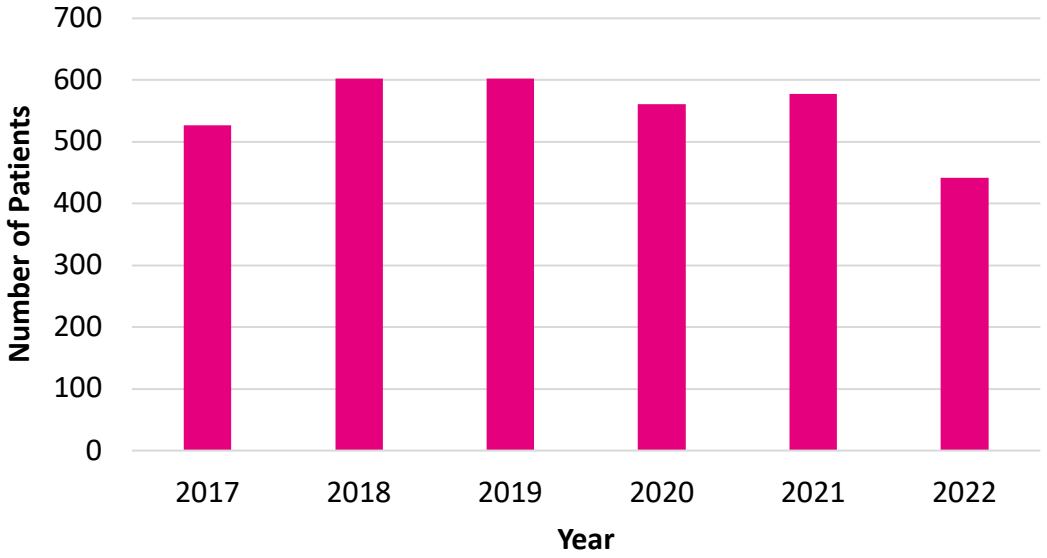
Figure 15. Adult EOLC Patients on FNHC Caseload from 2018 to 2022 (Source: FNHC)



Patients on the GP register for Palliative Care

Placing the patient on a GP Palliative Care Register has been shown to lead to better coordinated care, by triggering specific support. In Jersey, monthly data on the number of patients on the palliative care register started to be extracted from EMIS in 2017 as part of the Jersey Quality Improvement Framework (JQIF). This data may exhibit some variability and potential limitations, requiring careful consideration for accurate interpretation. Nevertheless, Figure 16 shows the peak of patients in need of palliative care registered in EMIS each year.

Figure 16. Highest number of Patients Annually on the GP Palliative Care Register from 2017 to 2022 (Source: HCS Primary Care Governance)



Care Homes and Care Agencies using Gold Standards Framework (GSF)

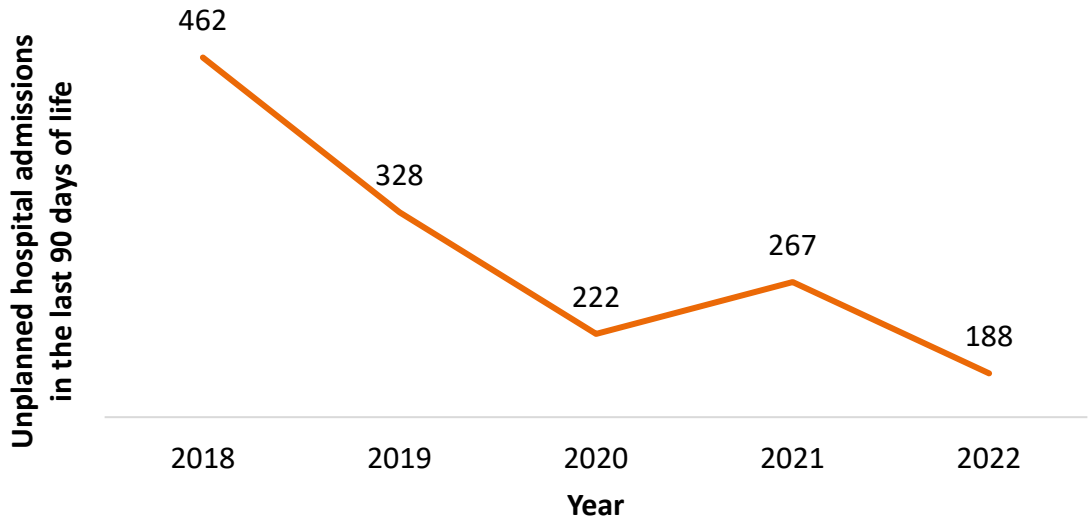
During the implementation phase of GSF, training was provided to staff members at 25 care homes and 13 care agencies.

Unplanned Hospital Admissions in the Last 90 Days of Life

Unplanned hospital admissions are a good indicator of how well the health and social care system is serving people in the last year of their life. If our care is well-planned then emergency admissions and visits to emergency departments should be a last resort (24).

In Jersey, since 2018 we can clearly observe that the number of patients that die in the following 90 days after a hospital admission has been decreasing and the number of deaths in 2022 is approximately a third from 2018 (Figure 17).

Figure 17. Unplanned Hospital Admission on the Last 90 Days of Life (Source: HCS)



This trend shows that the services offered in Jersey to support a patient with palliative and end of life care needs is improving and likely to lead to better outcomes. Reasons for these positive trends could include the introduction of the GSF, advance care planning and personalised care records along with increased awareness of palliative and end of life care options among healthcare professionals and the general public.

Data from England show an opposite tendency from 2009 to 2018 where there was an increase of 33.9% of people with 3 or more emergency admissions in the 3 months before they died (25).

A recent development to improve access has been the introduction of out of hours community nursing which enables patients in the community to receive appropriate and timely care. Furthermore, support and partnership working with the Emergency Department, FNHC and the Specialist Palliative Care Team has resulted in faster access to palliative care assessment, hospital admissions prevention and rapid discharge from hospital when appropriate.

Whilst there is recognition that the Long Term Care Fund has been put in place to financially support patients' care in the community, there continues to be an issue around timely access to care funding at end of life.

Addressing The Challenges of End of Life Care in Jersey

Ambitions for End of Life Care

The development of this strategy has been informed by a range of national and international strategies and developments in palliative and end of life care as well as work that has been undertaken in Jersey. Our aims are framed by the Ambitions for End of Life Care (14), a national framework that provides evidence-based principles which are then translated into local action (Figure 18).

This strategy offers a framework which will support commissioners and providers in achieving the following outcomes as identified in the national evidence-based framework Ambitions for End of Life Care (14).

Figure 18. Ambitions for End of Life Care

Community Awareness

Even though death and dying is a certainty we all face, it remains a difficult subject to discuss. This is particularly so due to the cultural sensitivities of island-life within Jersey and its demographic breakdown. It is apparent not just within our community but also across health professionals that there is often a reluctance to have difficult conversations.

Enabling and empowering people and health care professionals to make plans around their own end of life care and choices and to share these with family and loved ones will ensure they support those wishes when the time comes.

Each year Jersey Hospice Care (JHC) invests in a Dying Matters Campaign aligned to Hospice UK which looks to motivate the community to get involved in this crucial area that impacts on each and every one of us.

The concept of good end of life care is regularly promoted through social media channels thereby constantly keeping the discussion at the forefront of our community's mind.

Palliative and end of life care is everybody's business and by highlighting this to all stakeholders will not only increase their awareness but also increase recognition that we all have a social responsibility to help and be involved.

Holistic Support

End of life care can be provided in a variety of settings depending on individual needs and preferences. However, it tends to be provided at home, in a care home, in a hospice or in hospital (4).

When an adult is approaching the end of their life, to provide the right support when it is needed, an initial holistic needs assessment should be carried out with the person and documented. This will enable consideration of all aspects of their wellbeing, spiritual, health and social care needs and ensure that their concerns and problems are identified so that support can be provided to address them (26).

A valuable tool to perform a holistic needs assessment is the Integrated Palliative Care Outcome Scale (IPOS) (27). The IPOS is a valuable tool for improving the quality of palliative care and is used to assess physical, psychological, social, and spiritual symptoms and concerns of people receiving palliative care. It is a brief tool that can be completed by patients, their family members, or healthcare providers.

Early Identification of Palliative Care

Historically, it was assumed that palliative care would commence only once all treatment aimed at 'curing' people had finished. Now, it is well-accepted that there is benefit in providing palliative care in association with disease-modifying therapies that aim to prolong life. It is also recognised that many people with life-limiting illnesses are not 'cured' but continue to live with these illnesses for many years.

Healthcare providers can be supported to promptly identify adults who are likely to be near the end of life by using a systematic approach like the Gold Standards Framework Proactive Identification Guidance. Guidance can ensure that people can have their needs assessed and managed, and their carers and people important to them can also be offered support, offering the opportunity to make informed decisions about their care, make plans for their future and establish their preferences for how and where they would like to be cared for and die (28).

Gold Standards Framework

In order to support a consistent approach to palliative and end of life care, Jersey embarked on a transformational journey with the introduction of a nationally accredited framework for the care of patients in their last years of life called "The Gold Standards Framework".

Jersey is now internationally recognised as the only jurisdiction to implement this framework across all its health boundaries, as cited by Prof Keri Thomas, the founder of the Gold Standards Framework (GSF) (29).

This three-year programme gave all health and social care professionals in Jersey General Hospital and across the community the opportunity to learn about how to identify patients in their last years of life, assess and plan their needs throughout their journey both before and following death, and those of the family and carers.

This journey also led to the development and introduction of key policies and documents to support throughout this period such as the island wide DNACPR Policy and record, advance care

plans (ACPs), anticipatory medications in the community for end of life care and the Personalised Care Record (PCR) to support the care of the patient in the last days of life.

Advance Care Planning

“Advance Care Planning” is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes and priorities for care (30).

Advance Care Planning should happen after a holistic needs assessment to ensure that it fully takes into account all of the things that are important to the person. It is an ongoing process, so the advance care plan may change over time, based on the person's circumstances and wishes (28).

Over the last eight years a great deal of work has been undertaken across Jersey to support patients as individuals and share their advance care plans.

Preferred Place of Care

End of life care can be provided in a variety of settings depending on individual needs and preferences. However, it tends to be provided at home, in a care home, in a hospice or in hospital (4).

The preferred place of care is a person’s choice of where they would like to receive end of life care. The preferred place of care can have a significant impact on the person’s quality of life and their sense of comfort and dignity. People who are dying often have strong preferences about where they would like to receive care.

Treatment Escalation Plan

The Treatment Escalation Plan (TEP) Guideline (31) was approved in February 2023 by the Policy & Procedure Ratification Group (PPRG). The TEP helps healthcare professionals, patients and those close to the patient communicate about the patient care. It also helps to ensure that the patient receives the right level of treatment, regardless of the stage of illness that deterioration occurs. It promotes patient autonomy and shared decision-making between patients, relatives and clinicians ensuring patient preferences are considered.

“Treatment Escalation” is the process of increasing the level of care provided to a patient as their condition worsens up to a designated “ceiling of treatment” promoting a proactive, collaboration approach to end of life care planning and improving decision making in the event of a deterioration.

The TEP is reviewed regularly, at least weekly, and updated as needed. It is important to note that the TEP is only valid for the duration of the patient’s current admission and documented in the notes.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

DNACPR means that if a person has a cardiac arrest or dies suddenly, there will be guidance on what action should or should not be taken by a healthcare professional. This includes not performing CPR on the person given the fact that this is not always successful and does not work for patients with advanced and irreversible illness. It is crucial therefore, that discussions

regarding DNACPR are introduced to increase the possibility of a peaceful and dignified death (32).

When done well, DNACPR decisions are an important aspect of advance care planning, and people should be fully involved in discussions about their care.

The Jersey Multi-agency Unified DNACPR 16 years and over Policy (33) was ratified in February 2021 with the following purposes:

- To ensure that a patient can have a dignified and peaceful death
- A dying patient may be at risk of a cardiac or respiratory arrest where CPR is not clinically appropriate
- The risks and uncertain outcome of CPR could outweigh any potential benefits
- A patient with capacity has expressed a clear wish to no be given CPR
- Good practice for healthcare professionals set out in GMC's end of life care guidance.

Personalised Care Record

This care record is designed and in place to support best possible clinical care at the end of life in accordance with the person's needs and wishes. It is a multi-organisational document to be used by all professionals and is to be shared with the person, their family and carers. It is designed to record the communication and collaboration between the multi-professional team, individual adult patients and their family / carers.

The development of the "personalised care record for the last days of life" (PCR) incorporates all of the patients' wishes and preferences enabling health care professionals to do all they are able to meet these needs.

Anticipatory Medications in the Community

Anticipatory prescribing means making sure that someone has access to medicines they will need if they develop distressing symptoms at home or in a care home. The medicines are prescribed in advance so that the person has access to them as soon as they need them (34).

Anticipatory medicines are often given towards the end of life. However, these are all medicines which can be used for symptom management and given at any point in someone's illness if they need them (34).

An individualised approach to anticipatory prescribing should ensure that the drugs prescribed are appropriate to the anticipated needs of the dying person, and prevent distressing hospital admissions and waste of medicines (35).

Jersey Hospice Care, Family Nursing & Home Care and General Practitioners have put in place an island-wide policy for "Just In Case" (anticipatory) medicine to support patients in the community in terms of their symptom management at end of life.

Integrated IT System

The development of an Adult Specialist Palliative Care Team has brought together all the health and social care providers involved in the care of the patient to ensure that decisions around treatment plans and escalation are shared.

Shared advance care plans are central to coordinated palliative and end of life care, ensuring critical information is available during emergencies and that people are not required to repeat information each time to their care provider.

The introduction of the electronic patient record system (EMIS) within the community has seen patient records being shared between GPs, FNHC and JHC and improved communication between community organisations. However, the information contained within the digital patient record is not easily available to all other health care providers and community plans are not visible in hospital electronic patient records or Jersey Ambulance systems. At present practitioners are dependent on paper copies to ensure key information is available.

This enables care preferences, treatment recommendations and other advance care plans for patients approaching end of life to be shared. A list by GP surgeries of people under their care who may be approaching the end of life is held to facilitate this, the Palliative Care Register. GPs hold monthly GSF meetings in the community which JHC and FNHC attend to discuss patients on their palliative care registers.

Services

The infographic below gives an indication of the services involved in supporting a patient and their family with palliative care needs.

Figure 19. Services Involved in Providing Palliative Care

Coordination of Care

There is recognition that as people live longer and with the increasing prevalence of chronic conditions, it is essential that all care providers collaborate to meet the challenge of planning and delivering high quality palliative and end of life care services for increasing numbers of patients, families, and carers across Jersey.

Strong relationships have been built across the care sectors including statutory, community, Primary Care and third sector who are all committed to build on those achievements and continue to improve care at a time when Islanders are at their most vulnerable. We all want to ensure that people are encouraged to have conversations about what matters to them, to reduce unnecessary hospital admissions or reduce the length of stay and to ensure that all those who work with people nearing the end of their lives feel confident and competent in delivering care.

We want to make sure our services are accessible to all and that care is coordinated; the right care is delivered by the right person at the right time in the right place.

Community services have been developed across a wide variety of providers to support many people through day and outpatient services ensuring there is the availability for physical rehabilitation, reablement, emotional support, medical support and educational support. They have developed close working relationships with the respiratory and cardiac teams to ensure there is seamless support for all these patients.

FNHC continue to deliver home-based palliative and end of life care to support patients and their families and carers in the place they call home.

A standard operating procedure has been developed to avoid the duplication of health care professionals in the patients' home and is in place to ensure the patient is clear on which team is leading on their care. This is particularly relevant and pertinent as patients approach their last days of life.

Alongside the Personalised Care Record, further work has been done to develop a rapid discharge pathway to ensure patients who do not want to be in hospital can be discharged with all the required support efficiently.

Whilst Jersey is currently in the fortunate position of having both generalist and specialist palliative care services, there is more work to be done to build these services, ensuring all are aware of their scope of practice avoiding duplication, bridging gaps and developing the workforce.

Workforce

Specialist Palliative Care

Significant progress has been made in Jersey since the pivotal decision to develop an adult Specialist Palliative Care Team was made by Jersey Hospice Care in 2014 following the publication of the 2012 White Paper, “Caring for each other, caring for ourselves”.

The formation of this team saw, for the first time in Jersey, a team working across all health boundaries to provide consistent, seamless care to patients with palliative care needs and their families.

This team has brought together all the health and social care providers involved in the care of the patient to ensure that decisions around treatment plans and escalation are shared. The introduction of the electronic patient record system (EMIS) within the community has seen patient records being shared between GPs, FNHC and JHC.

As the services developed, there has been further investment in the Specialist Palliative Care Team to support the medical model which has culminated in this service becoming a consultant-led service, with on call consultant advice 24 hours per day, 7 days per week.

Specialist Palliative Care Services can be accessed by any care professional, family or patient. Patients will be triaged within 24 hours and signposted to the most appropriate service at that point. This referral process does not discriminate against any group.

Education

Education has been key to the success of palliative and end of life care to date with programmes available around symptom management, communication skills, end of life care, syringe pump training as well as several post graduate courses in palliative care. This is evidenced through the reduction in admissions to Jersey General Hospital and the increasing numbers of patients achieving their Preferred Place of Death. The continuation of this will be crucial to the success of this strategy as our workforce changes and develops. The need for palliative care education that is delivered in an integrated, collaborative and cost-effective way is well documented (36).

Over the last five years there has been an increased focus on palliative and end of life education and training following the implementation of the GSF Programme. The commencement of an Education Team at JHC who have devised an education strategy to address the learning needs across the hospice and beyond to support the competency at generalist and specialist levels. Other courses are delivered by other providers including Qualifications and Credit Framework (QCF) qualification. The courses provided by JHC available to all stakeholders across the Island are as follows:

Table 3. Available Education Provided by JHC

Course Title
Advanced Care Planning
Communication Skills: Advanced
Communication Skills: Foundation
Communication Skills: Intermediate
Enhancing End of Life Care: Skills Based Training for RGNs

Course Title
Post-Graduate European Certificate in Essential Palliative Care
Opening the Spiritual Gate
Palliative and End of Life Care Essential Training for RGNs and HCAs
Principles of Palliative and End of Life Care: Foundation
Sexuality, Body Image and Dignity
Understanding and Managing Grief and Loss

There are also various study days that are offered by HCS, FNHC and JHC such as syringe pump training, Personalised Care Record training for care in the last days of life, Anticipatory Medications and Drug Calculations. Other study days are also available.

To support health and care professionals, course programmes have been established in advanced communication skills, advance care planning, symptom management, last days of life care, syringe pump training, spirituality training to name a few.

Within JHC, there have also been further developments in terms of holding reflective practice sessions and formal Mortality and Morbidity meetings to review practice, learn from experience and improve outcomes for patients and their families.

Nevertheless, the pandemic escalated the demand and brought the issue of death and dying to the forefront of the minds of professionals and the public alongside clearly identified training gaps, particularly around symptom management, breaking bad news and Advance Care Planning. Global and national reports (37), (38) demonstrate the need to upskill the existing healthcare workforce as it becomes increasingly apparent that caring for people with life limiting diseases is the responsibility of all.

Governance Arrangements

This strategy is consistent with the aims of the Government of Jersey (GoJ) Strategic Plan (39) and the Health and Community Services Business Plan (40). The emphasis is now on increased collaboration and shared accountability. This commitment has led to the formation of the Jersey End of Life Care Partnership Group and the development of this Palliative and End of Life Care Strategy for Jersey.

Jersey End of Life Care Partnership Group (EoLCP)

The EoLCP was formed in 2021 to work with stakeholders with a vision of ensuring all Islanders with a life limiting illness have access and informed choice to the right care, by the right person, at the right time and in the right place.

The EoLCP has been set up to involve stakeholders across services including GPs, the prison, mental health, community and hospital representation. This group is well placed to identify gaps in service provision and ensure they are a priority. It also enables stakeholders to gain a wider awareness of the various teams involved in the care of an individual patient.

It is imperative that all stakeholder groups position themselves to be able to ensure they can provide the requisite end of life services in the community. Its membership is shown in Table 4 and the stakeholder engagement event discussion summary can be seen in Appendix 1.

Table 4. Jersey End of Life Care Partnership Group Membership

Member Organisation	Representation
Care Agencies	Chairperson, Jersey Care Federation
Dementia Jersey	Lead Dementia Adviser and Counsellor
Family Nursing & Home Care	Operational Lead Adult Services
Funeral Directors	Representative, Pitcher & Le Quesne Representative, de Gruchy Funeral Services Representative, Maillard Funeral Services
Government of Jersey	Director of Local Services (CLS) Education Lead (HCS) General Manager for Medical Services (HCS) Head of Prison Healthcare (JPS) Improvement and Innovation Lead (HCS) Medical Director for Primary Care (HCS) Senior Ambulance Officer (JAS) Senior Change Manager (HCS)
Jersey Care College	Education Lead
Jersey Care Commission	Senior Regulation Officer
Jersey Hospice Care	Chief Executive Director of Clinical Strategy Director of Palliative Care Services Palliative Medicine Consultant
Les Amis	Chief Executive
MacMillan Cancer Support Jersey	Chief Clinical Officer
Primary Care Board	Representative GP

Working Group

A working group was established to undertake the development of the Strategy with the support of Government of Jersey Commissioning, Public Health and Improvement & Innovation as shown in Table 5.

Table 5. Working Group Membership

Member	Organisation
Director of Palliative Care Services Director of Clinical Strategy Executive Assistant	Jersey Hospice Care
Consultant in Public Health Senior Change Manager (HCS Commissioning) Change Manager (HCS Improvement & Innovation)	Government of Jersey

Stakeholder Engagement

Patients, Families and Carers

The following feedback demonstrates a family's experience of services across the system when approaching end of life.

"Following diagnosis of Stage 4 duodenal cancer, our mother attempted several cycles of chemotherapy. Unfortunately, she was plagued with reoccurring sepsis infections and other complications. There were countless visits to hospital and the Emergency Department, overnight stays in the AAU and several surgical procedures over the first few months following her diagnosis. It was a rollercoaster which she faced with great courage and bravery. Ultimately, however, the treatment was unsuccessful, the cancer was too strong, and as such, we were introduced to your team at the Hospice for palliative care."

"Mum spent a week as an inpatient at Hospice. The staff and volunteers we met there were, without exception, kind, helpful and knowledgeable. The facilities you have are wonderful and I remember Mum saying that it was like arriving at a 5 star hotel after her weeks at the hospital! I also remember feeling a sense of calmness and being hugely reassured and comforted by your staff, and by the superb level of care they gave her. Above all, they seemed to have so much time to help Mum. I am sure they were terribly busy but you never got that impression. We are hugely grateful to all of the staff and the volunteers at Clarkson House for their care over that week."

"Mum decided that her preference was to go home and to remain at home for the duration of her illness. We were introduced to our Community Palliative Care Nurse, and she very quickly became an absolutely vital part of Mum's care and the most important support to my brother and I during what was a very difficult few months."

"She was well organised and we were impressed with the sharing of information between her, Family Nursing and the GP. She made sure we knew who to call, when and what for and always informed us if she was going to be away from work."

"There were times, particularly towards the end, when my brother and I felt overwhelmed by Mum's illness and genuinely concerned that we couldn't provide her with the care at home that she needed. Our nurse's reassurance, expertise and daily "summaries" were particularly vital at this time. We as a family cannot thank her enough for her help and for literally carrying us through those last weeks of Mum's life."

"When Mum died we were heartbroken to have lost her but comforted that we were able to fulfil her wish to die at home. It was not easy but everyone involved in the community made it possible. We are so very grateful to them all."

Patients and carers were invited to independent confidential focus groups to discuss key themes and ensure the overarching stakeholder engagement event was meeting the needs of those who use the services.

They were asked two key questions:

1. What matters most to people in their last year of life?
2. What does excellence look like?

The feedback from these questions was central to the planning of the stakeholder event and it can be found in Table 6 and Table 7.

Table 6. Patient and Carer Feedback to Question 1

What matters most to people in their last year of life?
All agreed that this was very dependent on what stage of diagnosis, treatment and trajectory of illness someone was in. However, the key points that came up from the discussion were: • A need for symptom control (particularly pain) if nearing the end of life • A multi-disciplinary connected approach to care for the individual AND the family • Clear and honest conversation with the individual and the family – checking with them what would be helpful to know including what information would help in the last days of life… and keep checking • What is important to somebody during their life is likely to still be important towards the end – this will be different for everybody so needs focused conversations to find this out and individualised care • Open mindedness to different approaches • Quality of time with those around them – who is bringing them peace or comfort in some way • Spiritual needs in the broadest sense (could be religion, nature, water, music) • A feeling of control of what is happening • A realistic choice about where the individual can end their life in dignity and pain free • Relationships

Table 7. Patient and Carer Feedback to Question 2

What does excellence look like? (Including gaps also and potential improvement)
• A co-ordinated multi-disciplinary individualised 24 hour approach that is 'effortless' for the individual and the family to access regardless of their circumstances and can be continuously renegotiated depending on the needs of the individual • A well-trained workforce across all settings where palliative and end of life care is provided to ensure that the communication, symptom management, privacy and care is consistent wherever the individual receives care to ensure that the individual is able to die with dignity in a place of their choice • Wrap around care to encompass the individual and family which includes clear and sensitive communication and information provision at all stages of their choice • Options: which may include information about and option for Assisted Dying at a time and place of patient's choosing if approved in Jersey • If an individual chooses to die at home, there is a need for a specialist support and information to support this • Increased island-wide bereavement support should be available when it is required – structured approach to offering this in the months following a loss even if it has previously not been taken up • More public awareness and acceptability of discussing the process of dying in families and in employment so that wishes are known and support can be offered (e.g., Advance Care Planning and employment support for sick leave or bereavement leave)

Additional feedback from an attendee has been highlighted:

"I was very surprised to learn that Hospice only have 12 beds. It was great to hear first-hand of people's experiences with the level of support that is currently available. As there are such limited spaces at Hospice it must mean that patients end up dying at home with little specialised support after 11pm, or in hospital where we don't have a dedicated Palliative Care team or Palliative Care Ward. Patients and their families want their passing to be dignified, no one should have to remember that the last cherished moments with a loved one were behind Hospital curtains on a busy ward with absolutely no privacy. The few people I have spoken to that this has happened to were quite traumatised by their experience because of the lack of privacy at such an awful time."

"When my father died at 55 years old my mother just got a phone call. He had MS and his condition was deteriorating and she left the ward with specific instructions to ring if he worsened. The ward rang at 8.00am and informed her over the phone that he had died in his sleep and just contact your undertaker to collect his belongings. This was a few years ago, but it stuck in my mind that it was so insensitive and heartbreaking to hear that bombshell on the phone. I know that has been the case for many people due to COVID, but not then."

Professionals

In February 2022 we held the End of Life Care Engagement Event with key stakeholders from the various organisations and sectors represented (Appendix 1). In the first part of the session and with the support of a facilitator, they were asked to identify the enablers and "stones in the shoes" in providing palliative and end of life care in Jersey (Table 8).

Table 8. End of Life Care Engagement Event - Task 1

Task 1	Identifying our enablers and "stones in the shoes" (combined feedback)
Enablers	**Stones in the shoes**
Compassionate island Effective signposting / coordination of care Excellent end of life care Good civil society and partnership working Multi-agency / partnership cooperation Resilient staffing	Difficulties getting off island Financial issues Inconsistent / inequitable access Limited data sharing (patient care record) Service issues – poor out of hours provision / limited equipment in the community / repetition / inconsistencies / transition amongst services / single point of access Staffing issues – recruitment / retention / immigration / upskilling / limited volunteer collaboration

The second part of the End of Life Care Engagement Event was focused on four key questions. The attendees were divided in four groups that with the support of a facilitator were guided through a discussion on one of the key tasks and the essential themes that emerged are shown in Table 9.

Table 9. End of Life Care Engagement Event - Task 2

Task 2	Separate Themes
Group 1: How will we know we are getting it right?	
Need island-wide approach – island-wide strategy / policy; shared pathways; centralise data with information sharing Aging demographic – equitable access for all Competent workforce – succession planning and recruitment Inter-charity / organisation communication and knowledge of service / roles Risk management	
Group 2: Integrated care pathways	
Service capacity is a key limiting step Need for Care Coordinator – assigned for pathway signpost / guide patient and act of information source for HCPs Delays create anger / worsening outcomes – avoid MDT fishing exercises / bouncing between services No central data hub; Ambulance lacks information when attending; disseminating information is limited and challenging Access to care issues verge on rationing – LTC can assist / have flexibility but need to be signposted early	
Group 3: Developing the workforce	

COVID difficulties – only e-learning continued but face-to-face preferable due to subject matter
Recruitment / retention challenges, review pay for upskilling, undertake employment survey, promote palliative care nurse role (day in life, opportunities, shadowing), collective recruitment across the sector
JHC / HCS liaison very effective – further linkages / blended learning needed to join up / reduce duplication – Project ECHO, open up Learning Club, masterclasses, use of retail outlets for training
Gold / silver / bronze palliative care nurse pathway established – need university link to continue (key gap)
Expand training availability within HCS and community partners
Online programmes are effective but access limited due to cost
Group 4: Digital technology and innovation
Jersey has the fastest tech in world but lacks innovation – vision shared but devices not coming together
New developments – Telecare / Telehealth replacing CAS alarm; EPR by year end; virtual consultations; COVID was a catalyst
Issues with accessing resources and data – organisations have to start from scratch on referral
Concerns re data sharing – but lack of sharing compromises patient safety – public view should be gained to balance perfection vs progress, sharing vs hiding; public expectation is that organisations talk / share more
Central hub would assist access and remove duplication
Demographics risk – aging population

The stakeholder engagement event discussion summary can be seen in Appendix 1.

Quotations

Below are the selected quotations that represent several of the themes on Table 9. The quotations are verbatim, although in some instances they do not represent entire contributions in the interests of brevity and anonymity.

"We're a compassionate island. We've got a huge percentage of Islanders who want to step up and volunteer to help"

"They go round the houses, there's a delay and as a consequence there can be quite a lot of anger, patients can be really frustrated and rightly so"

"We've got the fastest connectivity in Western Europe, we're not maximising what's available. There's all sorts of technology that we could use to support people in their homes"

"There's lots of good partnership working, we've got some really good organisations, fantastically talented people who are very dedicated"

"It is so important that we work in partnership, government with all other providers, to serve Islanders and give them the very best care"

“What makes a difference in Jersey is the charitable sector, we are so blessed. So many people wanting to contribute”

Outcomes and Actions

Outcome 1 - People in Jersey who need palliative and / or end of life care will be seen and treated as individuals who are encouraged to make and share advance care plans and to be involved in decision

The key actions for achievement of Outcome 1 are:

1. To continue the development of GSF across Health Care Providers (HCPs) in the community and hospital in Jersey.

2. To develop a central, integrated IT system (for example EPaCCS in the UK (36)) across health and care professionals to facilitate the sharing of Advance Care Plans and GSF recording and collate outcome performance data.

Outcome 2 – People in Jersey who need palliative and / or end of life care will have their needs and conditions recognised quickly and be given fair access to services regardless of their background and characteristics

The key actions for achievement of Outcome 2 are:

1. To ensure all interested parties who represent patients requiring palliative care have a voice on the EoLCP.

2. To design and build a robust 24 / 7 model of palliative care that is accessible to, and meets the needs of, patients and families at a generalist and specialist level.

3. To educate and develop the workforce and volunteers, and increase public awareness, in relation to palliative care.

4. To consider access to emergency funding for end of life care and to responsive care in the community at end of life.

5. To collate public health data across all health care settings using a collaborative approach to IT systems and robust analysis with benchmarking.

Outcome 3 – People in Jersey who need palliative and / or end of life care will be supported to live well as long as possible taking account of their expressed wishes and maximising their comfort and wellbeing

The key actions for achievement of Outcome 3 are:

1. To develop standard operating procedures across all partnership providers.
2. To improve and build on the Jersey community services and initiatives as we face an ageing demographic and therefore an increased need for services.
3. To undertake work to differentiate between specialist and generalist provision to ensure the most cost-effective model is designed with patient preferences built in.
4. To ensure hospital referrals to community services are completed in a timely manner.
5. To improve communication across all areas of the health system.
6. To develop a transfer of care process.
7. To develop an educational focus for GPs and care homes around advance care planning and end of life care to seek to prevent avoidable admission to hospital.

Outcome 4 – People in Jersey who need palliative and / or end of life care will receive care that is well coordinated

The key actions for achievement of Outcome 4 are:

1. To ensure the right information is available at the right time to minimise duplication through the development of an integrated IT system across the whole health system in Jersey.

2. To expand and realign hospital discharge processes to present the opportunity to enable more people to transfer from inpatient settings to their preferred place of care with the care they require to support them as appropriate.

3. To ensure people receive the right care, at the right time, in the place consistent with their wishes and preferences avoiding the disruption of hospital admissions when they do not add value to care.

4. To develop a single point of access for referrals to help ensure patients have timely access to the most appropriate care in the most efficient way possible.

5. To develop an agreed pathway for access to anticipatory medicines and equipment out of hours.

6. To address care needs to support people to remain in their own home.

Outcome 5 - People in Jersey who need palliative and/or end of life care will have their care provided by people who are well trained to do so and are receiving ongoing training to maintain their skills and competencies

The key actions for achievement of Outcome 5 are:

1. To undertake a needs analysis of the health and care workforce across Jersey in terms of their knowledge and competence in palliative and end of life care.
2. To develop an island wide training plan and competency framework to support the entire workforce.
3. To develop consistent measurable standards and robust evaluation methods for quality education and training and ensure it is delivered by skilled and qualified providers.
4. To ensure all key staff are able, encouraged and supported to attend training programmes around core principles of palliative and end of life care.
5. To adopt a system-wide approach to the provision of palliative and end of life education. This should include all training providers across the island.
6. To extend membership of the Morbidity and Mortality Meetings to encourage island-wide attendance

Outcome 6 - People in Jersey who need palliative and/or end of life care will be part of communities that talk about death and dying and that are ready, willing and able to provide the support needed

The key actions for achievement of Outcome 6 are:

1. To ensure everybody's voice is heard through this engagement including the most vulnerable members of our community. This should pay particular attention to those groups within the demographics of Jersey which will see an increase in need for palliative and end of life care such as our frail, elderly population and those suffering with dementia and their families.
2. To develop a proactive approach and plan to galvanise support and spread the message across our communities. Working together we can improve the quality and continuity of the care experience.
3. To develop a 'Carer Strategy' to ensure we address and meet the needs of these members of our community. This strategy needs to be in line with the island-wide approach.
4. To undertake a care assessment in order to establish need. NB: Carers Jersey have already written an island-wide strategy which needs to be considered for adoption (41).
5. To develop a strategic approach to utilise the volunteer workforce effectively.
6. To combine all Third Sector elements to develop a robust, multifaceted model of care delivery which is supported by members of our community who are then reinforcing the need, spreading the message and having the conversations.

Key Enablers

In order to achieve the outcomes outlined, we have identified four essential enablers:

- The use of technology to inform, understand and improve care
- Education and workforce
- Public and patient engagement
- Co-design of island-wide palliative care pathway

The use of technology to inform, understand and improve care

Taking maximum advantage of digital solutions and innovations will be central to the delivery of this strategy.

The emerging digital landscape offers real opportunities for:

- Direct clinical care
- Coordination of services
- Communication
- Patient empowerment and self-management
- Quality improvement
- Understanding the population needs and impact of services
- Education and research

Whilst improvements have been achieved through the implementation of EMIS across certain community providers, there is a real opportunity to extend this to ensure there is shared access across all health care providers. The benefit of an electronic palliative care record for patients would incorporate advance care planning tools, DNACPR record, key conversations and treatment escalation plans to name but a few.

This would also provide the platform to interrogate the data thereby giving us quantitative measures for the key performance indicators required to measure the success of the overall strategy.

Work is already underway to ensure that we maximise on digital solutions through the upgrade of the telecare system on the Island that will support people in the community. For people on the end of life pathway, the focus of telecare is to deliver comfort for patients or reduce anxiety for the care giver by offering an additional layer of support. Patients can receive care with minimal disruption to their daily lives by providing individualised interventions and care from the comfort of their own home, improving self-management and care plan adherence.

Education and Workforce

Our health and social care workforce is our most important resource. An extensive range of staff roles with a wide variety of skills and specialisms are involved in caring for dying people. We want to ensure they have the skills, confidence and competence they need to deliver holistic, compassionate care for dying people and their families, regardless of where they are cared for.

At the same time, our workforce is also one of our biggest challenges. Difficulty in recruiting and retaining health care staff and maintaining stable teams with manageable workloads is a local and national problem that poses a real threat to the delivery and quality of care.

Lack of care support in Jersey is a very real issue that needs to be addressed urgently to support people to die at home.

There needs to be a strategic island-wide approach to address this issue. However, there is an opportunity within this strategy to make employment within this area an attractive career with a clear development pathway.

This strategy presents the opportunity to work together to co-design a model of care that requires all stakeholders to work collaboratively to meet the needs of patients and their families. This therefore gives us the opportunity to think about joint posts working across boundaries as well as maximising the utilisation of volunteers to support with the low-level support/befriending of patients and families. Consideration by Third Sector organisations of the pooling of their volunteer resources could make a tangible difference to capacity.

It is imperative that strategic decisions around education and workforce are in line with the island-wide strategy.

Public and Patient Engagement

There is absolute recognition that before we commence any of the workstreams we need to ensure we have set up public and patient engagement workshops to test the strategy and gain consensus to move forward.

By undertaking these initial workshops, we can co-opt lay members onto the other working groups to ensure there is real co-design embedded within this strategy.

This is crucial given we recognise that "*palliative and end of life care is everyone's business!*"

Co-design of Island wide palliative care pathway

There have been vast improvements in terms of joint working across the system but there is clearly further work to be done.

We need to identify all the key services required within the palliative care pathway recognising that there is a wealth of stakeholders across the community.

It is essential that there is full engagement in this workstream to ensure we design a robust, collaborative, cost effective 24 hour per day, 7 days per week model which meets the needs of patients and their families whilst avoiding duplication.

Patient and public engagement in this workstream will enable professionals to hear about the gaps in current provision and the impact of those gaps. It will then ensure we then address these gaps thereby improving patient experience going forward.

Design of this pathway will also give us the opportunity to identify key performance indicators for each part of the service involved. The draft pathway (Appendix 2) is to be discussed, amended and ratified initially by the EoLCP prior to ratification.

Success Criteria

Prior to measurement of the success criteria, it is imperative Jersey benchmarks itself against the National Audit of Care at End of Life (England and Wales) (42). This audit is aligned not only with national guidance including One Chance to get it Right, and NICE quality standards and guidance but also the Ambitions framework which this strategy is based around. This audit will support with further success criteria particularly aligned to carers and their support following a bereavement. These further success criteria would be agreed and ratified by the EoLCP.

In order to ensure that the actions we are taking are helping to improve patient and family experience and deliver the six outcomes set out in this document, we will initially track our progress against the following metrics:

1. 75% of patients with an expected death will have documented advance care planning which includes a treatment escalation plan and DNACPR record.

2. 100% of health and care professionals working across community, hospital and Hospice will have access to educational sessions around palliative care including GSF and end of life care on a monthly basis.

3. More patients will receive effective care, treatment and symptom control in the community. This will be demonstrated by ensuring that, for those patients who have a PPC within the community and an expected death, less than 30% experience an unplanned hospital admission in the last 90 days of life.

4. Services will be set up to enable more patients to achieve their wishes with these set out in their advance care plans. 75% of patients will achieve their preferred place of death.

5. 75% of patients will achieve their preferred place of care.

6. 100% of carers will be supported throughout the palliative care experience of their loved one.

Further work needs to be undertaken to establish and agree the methodology for collating all this information across all care settings to ensure we have robust data. Nevertheless, to support the road to success for this strategy, a draft of an Action Plan has been developed (Appendix 3). All elements need to be discussed, with agreed timelines, amongst all the stakeholders of the End of Life Care Partnership Group since it is imperative that implementation does not occur in isolation of other island-wide strategies such as the IT Strategy and the Intermediate Care Strategy.

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Appendix 1. Stakeholder Engagement Event Discussion Summary

Jersey Hospice Care
your care, your choice, your time

Event Discussions Summary

Event:	End of Life Care Engagement Event – 2 February 2022

Key Quotes	
We're a compassionate island. We've got a huge percentage of Islanders who want to step up and volunteer and help.	They go round the houses, there's a delay and as a consequence there can be quite a lot of anger, patients can be really frustrated and rightly so.
We've got the fastest connectivity in Western Europe, we're not maximising what's available. There's all sorts of technology that we could use to support people in their homes.	There's lots of good partnership working, we've got some really good organisations, fantastically talented people who are very dedicated.
It is so important that we work in partnership, government with all other providers, to serve Islanders and give them the very best care.	What makes a difference in Jersey is the charitable sector, we are so blessed. So many people wanting to contribute.

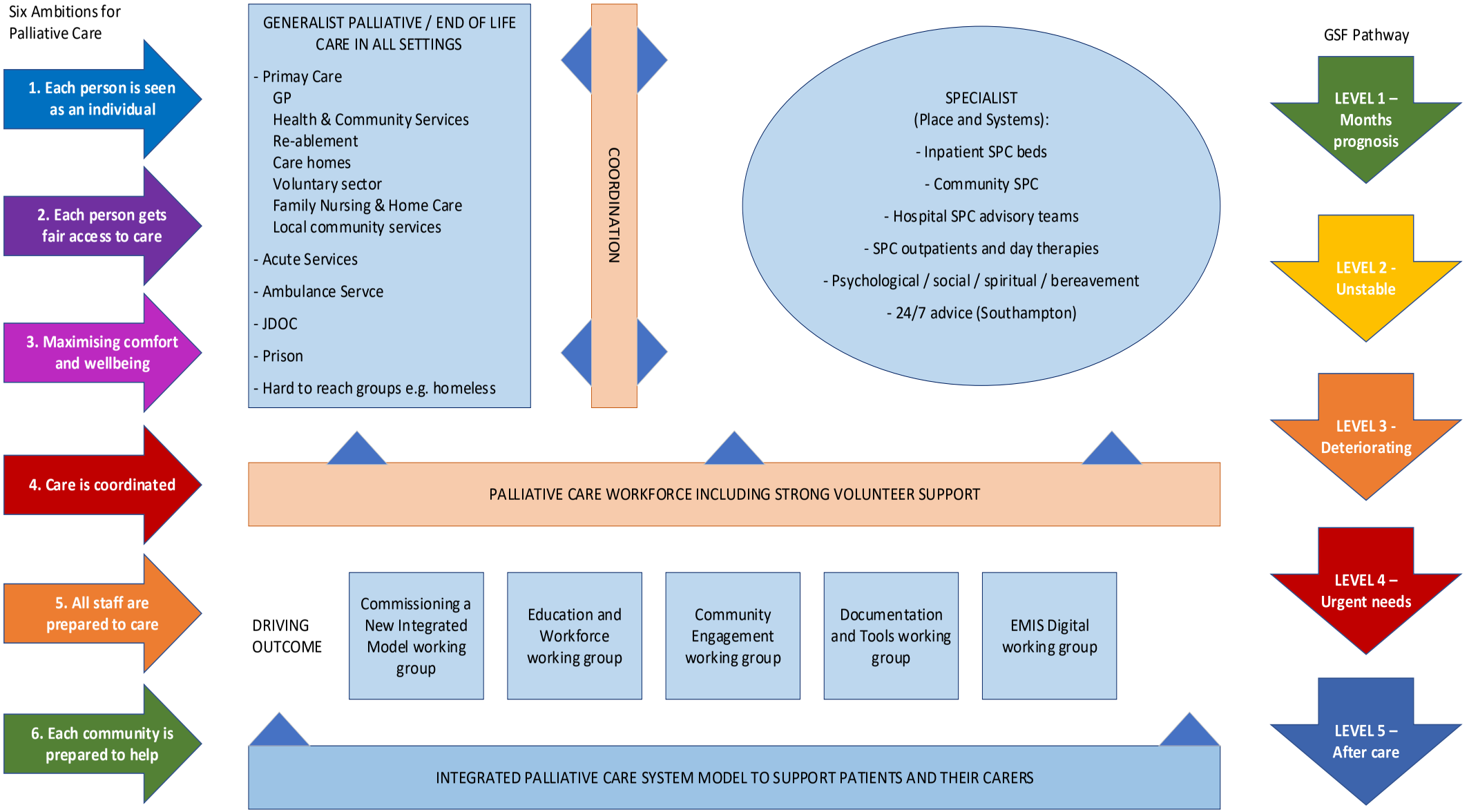
Task 1	**Identifying our enablers and "stones in the shoes" (combined feedback)**
Enablers	**Stones in the shoes**
Compassionate island Effective signposting / coordination of care Excellent end of life care Good civil society and partnership working Multi-agency / partnership cooperation Resilient staffing	Difficulties getting off island Financial issues Inconsistent / inequitable access Limited data sharing (patient care record) Service issues – poor out of hours provision / limited equipment in the community / repetition / inconsistencies / transition amongst services / single point of access Staffing issues – recruitment / retention / immigration / upskilling / limited volunteer collaboration

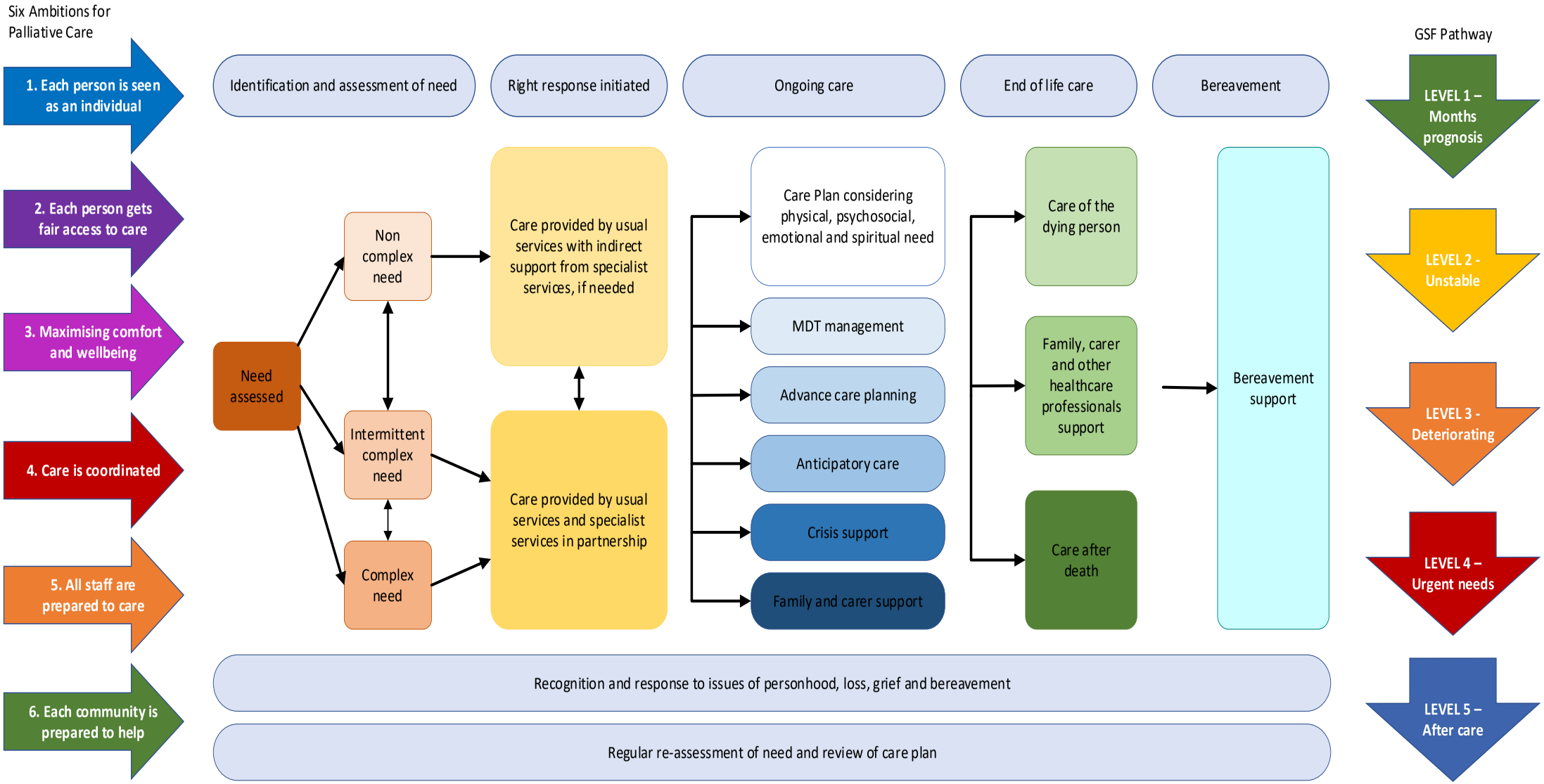
Task 2	Separate Themes
Group 1: How will we know we are getting it right?	**Group 2: Integrated care pathways**
Need island-wide approach – island-wide strategy / policy; shared pathways; centralise data with information sharing Aging demographic – equitable access for all Competent workforce – succession planning and recruitment Inter-charity / organisation communication and knowledge of services / role Risk management	Service capacity is a key limiting step Need for Care Coordinator – assigned for pathway to signpost / guide patient and act of information source for HCPs. Delays create anger / worsening outcomes – avoid MDT fishing exercises / bouncing between services No central data hub; Ambulance lacks information when attending; disseminating information is limited and challenging Access to care issues verge on rationing – LTC can assist / have flexibility but need to be signposted early
Group 3: Developing the workforce	**Group 4: Digital technology and innovations**
COVID difficulties – only e-learning continued but face-to-face preferable due to subject matter Recruit / retain challenges, review pay for upskilling, undertake employment survey, promote palliative care nurse role (day in life, opportunities, shadowing), collective recruitment across the sector JHC / HCS liaison very effective – further linkages / blended learning needed to for join up / reduce duplication – Project ECHO, open up Learning Club, masterclasses, use of retail outlets for training Gold / silver / bronze palliative care nurse pathway established – need university link to continue (key gap) Expand training availability within HCS and community partners Online programmes are effective but access limited due to cost	Jersey has the fastest tech in world but lacks innovations – vision shared but devices not coming together New developments – Telecare / Telehealth replacing CAS alarm; EPR by year end; virtual consultations; COVID was a catalyst Issues with accessing resources and data – organisations have to start from scratch on referral Concerns re data sharing – but lack of sharing compromises patient safety – public view should be gained to balance perfection vs progress, sharing vs hiding; public expectation is that organisations talk / share more Central hub would assist access and remove duplication Demographics a risk – aging population

Attendees	
Organisation / Sector	**Representatives**
Dementia Jersey	Lead Dementia Advisor and Counsellor
Family Nursing & Home Care	Director of Governance and Care Operational Lead – Rapid Response and Reablement Operational Lead – Adult Nursing Service
Funeral Directors	De Gruchy Funeral Care Representative Maillards Funeral Directors Representative
GoJ (Customer and Local Services)	Director of Local Services Long-Term Care Representative
GoJ (Health and Community Services)	Associate Director – Improvement & Innovation Education Representative General Surgical Representative Senior Clinical Auditor Practice Development Sister Senior Change Manager
GoJ (Strategic Policy, Planning and Performance)	Senior Policy Officer
GP / Primary Care Body	GP Representative
Jersey Ambulance Service	Associate Chief Ambulance Officer (Clinical Governance and Risk) Chief Ambulance Officer
Jersey Care Commission	Regulation Officer
Jersey Care Federation	Care Agency Representative
Jersey Hospice Care	Education Manager Director of Palliative Care Services Consultant in Palliative Medicine Senior Nurse – Specialist Palliative Care Team Volunteer Manager Chief Executive Officer Associate Specialist in Palliative Medicine Clinical Nurse Specialist in Palliative Medicine
Macmillan Jersey	Chief Clinical Officer Cancer Support and Wellbeing Practitioner

Attendees	
Organisation / Sector	**Representatives**
Minister for Health	Minister for Health
Scrutiny	Scrutiny Representative Scrutiny Representative Scrutiny Representative

Appendix 2. Integrated Model of Palliative and End of Life Care




Six Ambitions for Palliative Care
1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help
Identification and assessment of need
Right response initiated
Ongoing care
End of life care
Bereavement
Need assessed
Non complex need
Intermittent complex need
Complex need
Care provided by usual services with indirect support from specialist services, if needed
Care provided by usual services and specialist services in partnership
Care Plan considering physical, psychosocial, emotional and spiritual need
MDT management
Advance care planning
Anticipatory care
Crisis support
Family and carer support
Care of the dying person
Family, carer and other healthcare professionals support
Care after death
Bereavement support
GSF Pathway
LEVEL 1 – Months prognosis
LEVEL 2 - Unstable
LEVEL 3 - Deteriorating
LEVEL 4 – Urgent needs
LEVEL 5 – After care
Recognition and response to issues of personhood, loss, grief and bereavement
Regular re-assessment of need and review of care plan

Appendix 3. Action Plan

On re-constitution of the End of life Care Partnership Group this Action Plan will require review and agreement.

Key: Complete | Current / Ongoing | Not Started

		2022				2023				2024				2025				2026			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Pre-Ratification	Draft Document																				
	Engagement Event																				
	Presentation of strategy to EoLCP																				
	Submission of strategy for ratification																				
Post-Ratification	**Outcome 1 - People in Jersey who need palliative and / or end of life care will be seen and treated as individuals who are encouraged to make and share advance care plans and to be involved in decision regarding their care**																				
	Continue the development of GSF across HCPs in the community and hospital																				
	Develop a central, integrated IT system (for example EPaCCS in the UK (36)) across health and care professionals to facilitate the																				

sharing of Advance Care Plans and GSF recording and collate outcome performance data																			
Outcome 2 – People in Jersey who need palliative and / or end of life care will have their needs and conditions recognised quickly and be given fair access to services regardless of their background and characteristics																			
Ensure all interested parties who represent patients requiring palliative care have a voice on the EoLCP																			
Design and build a robust 24/7 model of palliative care that is accessible to, and meets the needs of, patients and families at a generalist and specialist level																			
Educate / develop the workforce / volunteers and increase public awareness in relation to palliative care																			
Arrange access to emergency funding for EoLC and to responsive care in the community at EoL either from the Long Term Care Fund or alternative sources																			
Collate PH data across all health care settings using a collaborative approach to IT systems and robust analysis with benchmarking																			

Outcome 3 – People in Jersey who need palliative and / or end of life care will be supported to live well as long as possible taking account of their expressed wishes and maximising their comfort and wellbeing																			
Develop standard operating procedures across all partnership providers																			
Improve and build on these community services and initiatives as we face an ageing demographic and therefore an increased need for these services																			
Differentiate between specialist / generalist provision to ensure the most cost-effective model is designed with patient preferences built in																			
Ensure hospital referrals to community services are completed in a timely manner																			
Improve communication across all areas of the health system																			
Develop a transfer of care process																			
Develop an educational focus for GPs and care homes around advance care planning and end of life care to seek to and prevent avoidable admission to hospital																			

Outcome 4 – People in Jersey who need palliative and / or end of life care will receive care that is well coordinated																				
Ensure the right information is available at the right time to minimise duplication through the development of an integrated IT system across the whole health system in Jersey																				
Expand / realign hospital discharge processes to present the opportunity to enable more people to transfer from inpatient settings to their preferred place of care with the care they require to support them as appropriate																				
Ensure people receive the right care, at the right time, in the place consistent with their wishes and preferences avoiding the disruption of non-value added hospital admissions																				
Develop a single point of access for referrals to help ensure patients have timely access to the most appropriate care in the most efficient way possible																				
Develop an agreed pathway for access to anticipatory medicines / equipment OOH																				
Address care needs to support people to remain in their own home																				

Outcome 5 - People in Jersey who need palliative and/or end of life care will have their care provided by people who are well trained to do so and are receiving ongoing training to maintain their skills and competencies																				
Undertake a needs analysis of the health and care workforce in terms of their knowledge and competence in palliative and end of life care																				
Develop an island wide training plan and competency framework to support the entire workforce																				
Develop consistent measurable standards and robust evaluation methods for quality education and training and ensure it is delivered by skilled and qualified providers																				
Ensure all key staff are able, encouraged and supported to attend training programmes around core principles of palliative and end of life care																				
Adopt a system wide approach to the provision of palliative and end of life education. This should include all training providers across the island																				
Extend membership of the Morbidity and Mortality Meetings to encourage island-wide attendance																				

	Outcome 6 - People in Jersey who need palliative and/or end of life care will be part of communities that talk about death and dying and that are ready, willing and able to provide the support needed	
	Ensure everybody's voice is heard through this engagement	To be reviewed and confirmed by Government of Jersey / Health & Community Services
	Develop a proactive approach and plan to galvanise support and spread the message across our communities	To be reviewed and confirmed by Government of Jersey / Health & Community Services
	Develop An island-wide 'Carer Strategy' to ensure we address and meet the needs of these members of our community	To be reviewed and confirmed by Government of Jersey / Health & Community Services (Carer Strategy already in place)
	Undertake a carer assessment in order to establish need	To be reviewed and confirmed by the End of Life Care Partnership
	Develop a strategic approach to utilise the volunteer workforce effectively	
	Combine all Third Sector elements to develop a robust, multifaceted model of care delivery which is supported by members of our community who are then reinforcing the need, spreading the message and having the conversations	To be reviewed and confirmed by the End of Life Care Partnership
Success	Baseline assessment against 2019 / 20 National Audit for Care at End of Life (England / Wales)	

75% of patients with an expected death will have documented advance care planning which includes a treatment escalation plan and DNACPR record															
100% of health and care professionals working across community, hospital and Hospice will have access to educational sessions around palliative care including GSF and end of life care on a monthly basis															
More patients will receive effective care, treatment and symptom control in the community. This will be demonstrated by ensuring that, for those patients who have a PPC within the community and an expected death, less than 30% experience an unplanned hospital admission in the last 90 days of life															
Services will be set up to enable more patients to achieve their wishes set put in their advance care plans. 75% of patients will achieve their preferred place of death															
75% of patients will achieve their preferred place of care															
100% of carers will be supported throughout the palliative care experience of their loved one															

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Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Patient Charter**		
Date of Meeting:	25 July 2024	**Agenda Item:**	**9**

Executive Lead:	Chris Bown, Chief Officer HCS
Report Author:	Carl Walker, HCS Patients' and Users Panel co-ordinator and facilitator

Purpose of Report:	Approval ☐	Assurance ☐	Information √	Discussion ☐
	This paper provides the Board with the Patient Charter, enabling patients to fully understand their rights when they are receiving treatment form HCS.			
Summary of Key Messages:	The key messages arising from this report are: - The inclusion of Martha's Rule (under clause 7): The implementation of Martha's Rule in HCS needs to be explored further. The Patients' Panel are happy for the Charter to be published in the first instance without reference to Martha's Rule on the condition that HCS is actively seeking to resolve this. - The intention is to develop a charter for Children / Young People to ensure their voice is heard. This will be a collaborative piece of work.			
Recommendations:	The Board is asked to endorse the Patient Charter.			

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

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
HCS Senior Leadership Team	11 July 2024	Approved

List of Appendices:
Patient Charter

MAIN REPORT

Background

Following discussions between the Panel and the previous Health Minister Deputy Karen Wilson at a Patients Panel meeting, Panel members learned that patients had rights in terms of the quality of care they receive, their right to a second opinion and the right to question the care pathway they have been placed on, among other things.

This led onto further discussions among Panel members, who were keen to see some kind of Patients' Charter – outlining the rights of patients – developed, approved and displayed/published to allow all patients to fully understand their rights when they are receiving treatment from HCS.

Process

Over the winter of 2023/2024, Patient Panel members researched and submitted their own suggested charters, or individual charter points, and all were collated and shared among the panel for discussion, thought or amendment ahead of a workshop-style meeting. At that meeting, held in the spring of 2024, the Patients' Panel collaboratively worked through all of the various suggestions for the charter and formed a ten-point guide for patients and users of HCS services in Jersey.

This first draft was then circulated among panel members for further consideration and was finalised at the next meeting, before being submitted to the HCS Senior Leadership Team for their observations and approval, with the hope that it would be signed off by the various care groups and executives before being displayed.

The submitted draft charter was amended slightly following a visit to a panel meeting by Medical Director Patrick Armstrong, before being resubmitted to HCS, and subsequently the Advisory Health Board for final approval.

END OF REPORT

Appendix 1:

HCS Patients' and Service Users Charter

1 All patients/users have a right to be treated with respect and dignity, and free from any form of discrimination.

2 All patients/users will receive utmost care throughout their treatment and aftercare.

3 All patients/users are entitled to clear information that can be easily understood, including the benefits, risks, alternatives, and any costs .

4 All patients/users are entitled to ask questions about their care, treatment or clinicians treating them.

5 All patients/users can ask for another suitably qualified member of staff to explain anything they do not understand.

6 All patients/users have a right to receive support for any language, mental health, sight, hearing or other difficulties

7 All patients/users, or their carers, guardians or parents, are able to make their own decisions, without pressure, about their treatment, and be free to change their mind or request a second opinion.

8 All patients/users have the right to make a complaint, have it taken seriously and have it acknowledged with a case number within three working days.

9 All patients/users should report anything which they see or hear which makes them feel uncomfortable.

10 All patients/users are encouraged to give positive feedback if they feel a member of staff has delivered an excellent standard of care.

To leave feedback on the care you have received, please call 01534 443515 or email PALS@health.gov.je or visit office at the main Parade entrance of the General Hospital.

This charter was written and published by the HCS Patients and Users Public Engagement Panel on behalf of all in-patients and out-patients receiving care in Jersey.

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Outcomes of the Ward Based Peer Reviews**		
Date of Meeting:	25th July 2024	**Agenda Item:**	**10**

Executive Lead:	Jessie Marshall, Interim Chief Nurse
Report Author:	Sonia Ferreira, Practice Assurance Lead Nurse

Purpose of Report:	Approval ☐	Assurance √	Information √	Discussion ☐
	A process of ward-based peer reviews is undertaken monthly. The full report describes the process and outlines areas of good practice highlight areas requiring improvement and ensure continuous learning and assurance across all wards.			
Summary of Key Messages:	Following a review of legacy ward care assurance process, • A ward-based peer review process has been implemented and is undertaken every month across HCS. The process involves both clinical and non-clinical staff and patient representatives visiting pre-determined areas in teams to review best practice and highlight opportunities for improvement. • The structure of these reviews involves a "15 steps" observation of the clinical area (taking approximately 2 hours) and involves discussions with both patients/service users and staff. • Following the inspections, the teams will have a group discussion sharing their individual thoughts and findings and agreeing on three areas of good practice and three opportunities for improvement. This will be then shared with the person in charge of the ward before the reviewing team leave the clinical area. • Following the inspections, all reviewing teams meet to further discuss their experience and feedback to the wider group. Care groups are invited to the initial feedback to provide an early opportunity for shared learning. • Any cause for concern is escalated immediately during the review to the ward leader. • An overview of all inspection feedback is recorded and sent to the appropriate care group teams and the outstanding actions followed up for evidence of completion at the care group governance meetings. • Areas which require escalation are reported at the monthly clinical governance reviews chaired by either the Medical Director or Chief Nurse **Areas of good practice noted:** • Overall, all clinical areas were very positive • Infection control compliance • Ward Cleanliness			

	• Housekeeping team recognised by patients and staff. • Staff care and compassion. **Areas for ongoing improvement** • Documentation – The Executive Directors have communicated with all professional groups to reinforce this statutory requirement. • The process will continue, and forms part of the ward-based care assurance process supported by visible senior leadership. • The programme has been further enhanced by weekly care rounding reviews undertaken by ward leaders visiting wards outside their speciality. These focus on care issues which have been brought to the attention of the Chief Nurse and ensures real time targeting of care and swift organisational learning. • It is proposed that the Quality, Safety and Improvement committee will receive a detailed quarterly report for assurance.
Recommendations:	The Board is asked to note the contents of the report.

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

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
None		

List of Appendices:
None

Main Report

The Peer Review Process (PRP) was successfully piloted in April, incorporating both internal and external reviewers to gather feedback and observations from patients and staff regarding clinical care delivery. The PRP has now been implemented across HCS at the General Hospital inpatient wards, as well as at Mental Health Inpatients, Sandybrook, and Samares.

Key Objectives:

- Celebrating areas of good practise
- Patient Safety: To identify and address practise issues that may impact patient safety.
- Best practises: Promote adherence to clinical guidelines, policies and procedures and evidence-base practice.
- Patient engagement: to understand the patient's journey from the patient's own perspective.
- Voice of staff within the clinical environment: to liaise with staff allowing them to feedback about working within HCS clinical areas.

Process and Methodology:

- Inclusivity in review panels: The PRP aims to foster a culture of inclusivity by inviting a diverse mix of professionals, including doctors, allied health professionals, non-clinical support services, and administrative roles, to join the review panels.
- Review cycle**:** A PRP cycle of 4 to 6-week reviews is being implemented throughout the year.

Feedback mechanism:

- Structured feedback sessions between assessors are held to discuss findings and provide mutual support.
- Constructive feedback focuses on three areas of celebration and three areas requiring improvement. Leads for each area disseminate the relevant information.
- Any concerns related to specific aspects of care are escalated through the appropriate care group.

Follow-Up Actions:

- Feedback plan**:** The Chief Nurse and the Practice Assurance Team will implement a feedback plan to promote a cohesive and comprehensive approach.
- Ongoing monitoring: Key aspects of care will be continuously monitored through care rounding to ensure ongoing improvement and accountability.

Areas of Celebration

- Cleanliness of the ward areas: All areas were clean, tidy, and conducive to care. Both the housekeeping team and ward team were congratulated for their efforts.
- Patient feedback: Patients provided overwhelmingly positive feedback regarding the care and compassion delivered in the clinical areas.
- Staff feedback: Staff members gave positive feedback about the visibility of ward managers and lead nurses, describing them as supportive, engaging, and highly visible.

Areas of Improvement

- Documentation: Despite observed improvements, certain aspects still require attention. The Practice Assurance Team is collaborating with the Digital Team to streamline nursing and medical documentation. All health professionals at the General Hospital are now using "Clinical Notes," which enhances communication among health professionals.
- Infection control requirements: There were gaps in adherence to the Appearance Policy, which were addressed immediately during observations. A new, updated policy will be launched in the coming week.
- Medicines management: Some aspects of medicine management are not aligned with policy. The Practice Assurance Team is working with Pharmacy to review the Medicine Security Audit and schedule more frequent audits to ensure compliance with key requirements.

Care Rounding

Care Rounding is a weekly assurance method conducted by the senior nursing team and the Chief Nurse Office at Jersey General Hospital. During these visits to acute areas, a snapshot assurance exercise is performed, focusing on specific aspects of patient care. Each session lasts approximately one hour and is followed by feedback to all area managers and lead nurses. The findings from these exercises inform areas requiring greater focus to ensure adequate patient care, compliance with care standards, and best practices.

Vision for the future
The PRP is an evolving initiative aimed at developing a comprehensive program that can be implemented across all areas within HCS and applicable to all professions. To enhance engagement and inclusivity, targeted communication efforts will be directed to all stakeholders.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Health and Safety Q1 2024 Report**		
Date of Meeting:	25 July 2024	**Agenda Item:**	**11**

Executive Lead:	Chris Bown, Chief Officer
Report Author:	John Gavey, Health and Safety Manager

Purpose of Report:	Approval ☐	Assurance √	Information ☐	Discussion ☐
	This paper provides an overview of Health and Safety activity in HCS for Q1 2024.			
Summary of Key Messages:	The key messages arising from this report are: • an overview of the HCS Health and Safety Team and resources within HCS • a summary of the key work undertaken during Q1 of 2024 • a summary of the key work planned for Q2 of 2024			
Recommendations:	**The Board is asked to note the report**			

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

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Executive Leadership Team	1 July 2024	Approved. For Board presentation.

List of Appendices:
Nil

Executive Summary

This report will provide an overview of the health and safety team acting as competent advises for HCS and a summary of the key work undertaken during Q1 of 2024.

All HCS employees have a duty for their own health and safety, and others through their undertakings.

The Health and Safety Team can advise the best course of action however the hazards, associated risks, control measures and the ability to mature Health and Safety culture is owned by Managers and Team Leaders in the operational teams.

Finance / Workforce Implications

Nil

Risk and Issues

HCS has twenty-eight overarching health and safety risks inputted on Datix, these are reviewed as per the schedule and reflect the status for the whole of HCS. The topics are aligned with the Government of Jersey Minimum Standards permitting across departmental benchmarking and comparisons.

Health and Safety Risks	Initial Score	Current Score	Target Score
Health and Safety Management System RR 939	25	20	10
Occupational Health Surveillance RR 1192	16	16	8
Construction Work RR 1146	20	15	10
Contractors RR 1143	15	15	5
Hazardous Substances RR 1141	20	15	10
Lone working RR 912	15	15	5
Plant, Machinery and Equipment RR 1147	20	15	10
Violence and Aggression RR 959	15	15	10
Workplace Transport and Traffic Management Plans RR 1142	20	15	10
First Aid RR 1110	16	12	8
Noise RR 1228	12	12	8
Vibration RR 1231	12	12	8
Fitness to Work RR 1233	16	12	8
Confined Space RR 1109	15	10	5

Health and Safety Risks	Initial Score	Current Score	Target Score
Fire Management RR 1006	25	10	5
Fuels, Flammables and Pressure Systems RR 1232	10	10	10
Safe Handling RR 1096	20	10	10
Working at Height RR 1111	15	10	5
Work Experience RR 1235	15	10	5
Water management RR 1118	25	10	5
Display Screen Equipment RR 929	12	8	4
PPE RR 1234	16	8	8
Slips and Trips RR 1229	12	8	8
Work Related Stress RR 1239	16	8	8
Radiation RR 1236	10	5	5
Asbestos RR 948	15	5	5
Public Events RR 1238	12	4	4
Working Environment RR 1237	12	4	4

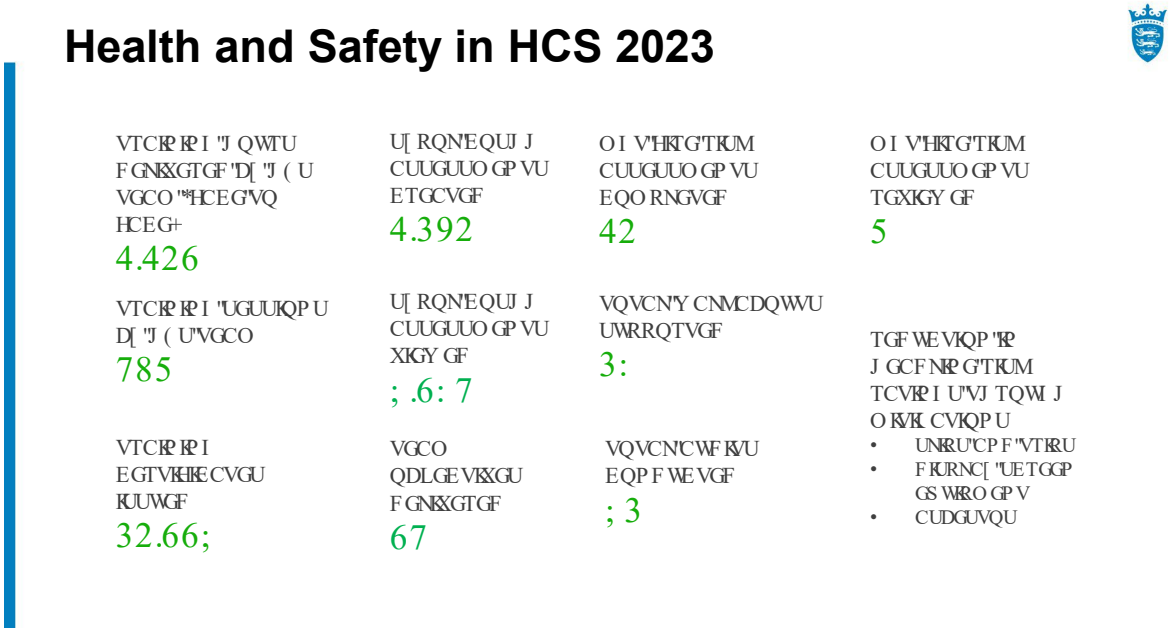
Main Report

The Health and Safety Management System refers to the way in which HCS manages health and safety throughout the estate, and how it can demonstrate its due diligence of an effective implemented approach. This risk entry is the collective of the other twenty-seven risks identified.

The HCS Health and Safety Team consists of eight FTE posts, all currently holding differing levels of competency and professional memberships. Namely there is one Chartered Member of IOSH (Institute of Occupational Safety and Health), one Certified member of IOSH, two Technical members of IOSH and two members of the National Back Exchange.

Personal development plans for each team member are reflective of their current levels of competency and the organisational needs in the short to medium terms. The team whilst trained as generalists also all have specialisms to lead.

Each year the team are set their personal objectives to assist with effective risk management across HCS, at the end of 2023 some of the key headlines delivered were as below.



The work undertaken during Q1 of 2024 included:

- Eight Health and Safety Walkabouts conducted by teams, six supported by the Health and Safety Team
- Three OurGov articles were published covering Health and Safety in HCS for 2023, the basics of Water Safety and Human Factors in the Health and Safety context.

- Twenty-six sample audits conducted covering Lone Working, Fire Safety, Control of Substances Hazardous to Health (COSHH), Safe Handling and the Prevention and Management of Violence and Aggression (PMVA).
- Occupational Health Surveillance service requirements based on the service health needs assessment for Pathology, Occupational Therapists and Catering have been reviewed.
- Health and Safety related training events have been published to the end of Q2 to allow teams time to plan rosters and attendance.
- The HCS Health and Safety Consultative Committee has met in January and March.
- The Mandatory and Statutory Training Programme has been supported through design and delivery of pilot events.
- The Jersey Safety Councils Behavioural Safety Leadership Worker course has been launched for the HCS Estate and Engineering Team.
- Deep dives were completed for the risks relating to Workplace Transport and Occupational Health Surveillance.

Based on the governance framework questionnaires, HCS's current status is as below:

Assurance Required	RAG	Comment
Legal Register is in place		Published on MyStates
Risk Register is in place		All 28 overarching health and safety risks managed through Datix
Internal Audits Undertaken		Sample audits undertaken
External/Cross Departmental Audits Undertaken		Ionising Radiation audit scheduled for June 2024
HCS specific arrangements (known as policies) in place		A number in place. Further to be drafted based on the release of Corporate Minimum Standards
Hazard Register (risk profile) in place		In place for all Care Groups
Health and Safety training matrix in place		HCS specific training matrix in place based on Corporate requirements
IOSH Safety for Executives and Directors Course (T1 and 2 Posts)		Course dates are available for the remaining attendees required to complete
Employee Consultative Committee		HCS H&S Consultative Committee met twice in this quarter

Training

During Q1 2,634 training certificates were issued and 153 face to face sessions were delivered by the Health and Safety Team. This continues a year-on-year trend of increasing attendance and accessibility to the core subjects.

Subject	2024		2023		2022
	Classes	Attendees	Classes	Attendees	Attendees
Fire Safety	54	775	26	424	402
Health and Safety	20	1115	12	1118	619
Maybo	45	353	41	388	496
Safe Handling	34	391	26	387	345

Contractor Management

The focus has been to review those used for construction led activities, aligning the work being undertaken by Jersey Property Holdings (JPH) to avoid duplication of effort. Where a contractor being used has not been reviewed by JPH the Contractor Health and Safety Assessment Questionnaire will be used from the Government of Jersey Minimum Standard to assure the same criteria is met.

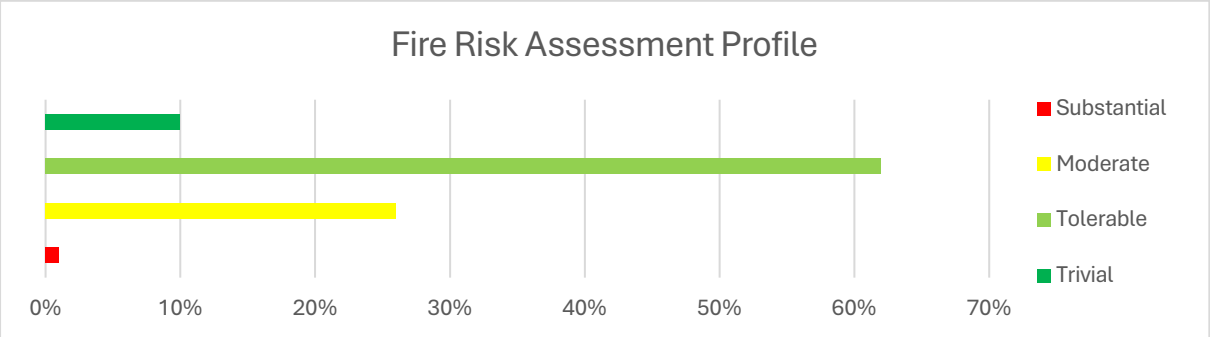
Prevention and Management of Violence and Aggression

After securing a dedicated training room with the move from Overdale to Enid Quenault Health and Wellbeing Centre, the volume of Maybo training courses has been increased to improve accessibility and providing tools for HCS staff to utilise when confronted with a violent or aggressive situation.

Fire Safety Management

95% of the HCS estates has a current fire risk assessment in place, this equates to 69 of 72 locations. The fire risk assessment is based on the PAS79 document and assess the effective management of fire risks within the given location.

The Q1 profile across the HCS Estate:



Planned Actions

Key work planned for Q2:

- Supporting the Corporate Audit for Ionising Radiation
- Review of the Single Assessment Framework consultation from the Jersey Care Commission
- Support the move from Overdale to St Ewolds for the Samares Ward
- Undertake Medical Gases Train the Trainer courses to enable the rollout of inhouse training.

- Occupational Health Surveillance health needs assessment to be reviewed for the Housekeeping Team
- Safe Handling Key Trainer initial training course to be delivered.
- Fire Extinguisher training to be designed ready to launch in July 2024
- Pseudomonas Risk Assessments are scheduled to be reviewed and updated.
- Review of six HCS Health and Safety related policies to be undertaken

Recommendations

The Board is asked to note the report

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Royal College of Radiology Report including a Review of Mammography Service**		
Date of Meeting:	25 July 2024	**Agenda Item:**	**12**

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

Purpose of Report:	Approval ☐	Assurance ☐	Information **X**	Discussion ☒
	This paper provides: • Information on the Mammography review • The recommendations and future steps for the Royal College and British Society of Breast Radiologists Report • Detail on communication strategy • Details of next steps			
Summary of Key Messages:	The key messages arising from this report are: • Failure, or lack of, governance structures resulted in a retrievable discrepancy being left for three years • Freedom to speak up is a valid mechanism for raising concerns • Cultural aspects both within and outside HCS impact reporting • A fair and just culture requires promotion			
Recommendations:	**The Board is asked to receive reports for information and approval**			

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

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Change Programme Board	Monthly	Board presentation

List of Appendices:
• Mammography review document • Royal College of Radiologists Report • Radiology Action Tracker

END OF REPORT

MAMMOGRAPHY REPORT

Mr. Simon West, MB BCh, FRCS (Edin), FRCS (Tr & Orth)
Deputy Medical Director

Mr. Patrick Armstrong, MBE, FRCS Ed (Tr & Orth)
Medical Director.

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Mammography Action Plan

Overview

In late August 2023 the Deputy Medical Director was made aware of concerns about the accuracy of reporting of mammography results for some patients. These cases spanned a period of 3 years at the time of the concerns being raised, and related to the practice of a single radiologist.

The patients had either presented for routine screening, were symptomatic breast patients or had attended for the placement of wires for the management of suspected breast cancer.

The ability of the radiologist to conduct cross sectional imaging reporting and plain film reporting (CT scans, MRI scans and X-ray interpretations) had been regularly reviewed as part of normal practice, including review in regular departmental Radiology Events and Leaning Meetings (REALMs). These are departmental feedback sessions as part of normal governance processes, which aim to highlight cases where errors may have been detected. It was determined that the ability of the radiologist to conduct cross sectional imaging reporting and plain film reporting (CT scans, MRI scans and X-ray interpretations) was safe.

In September 2023 the radiologist was advised that their participation in all matters relating to mammography and breast ultrasound must cease. It was decided the radiologist would continue to perform cross sectional imaging reporting and plain film reporting. This work would be monitored through an audit process using TMC, the external reporting service that HCS employs. In mid-February 2024 TMC delivered an audit which confirmed that radiologist's cross-sectional imaging and plain film reporting is of a good standard.

The Medical Director and Deputy Medical Director discussed the concept of an Invited Review by the Royal College of Radiologists (RCR) in late September 2023. This was commissioned shortly thereafter, and commenced in January 2024.

The immediate RCR recommendation was that a further review should be undertaken by the British Society of Breast Radiologists (BSBR). Accordingly, the Deputy Medical Director arranged a visit from two senior breast radiologists in March 2024 (the earliest that they could offer).

The BSBR review comprised a review of the radiologist's work including the cases of concern and a random selection of 20 screening cases, 20 asymptomatic cases and 15 wire localisation cases. Their report made further recommendations, which are outlined herein.

As part of the initial review into concerns raised, the Deputy Medical Director also discovered that some concerns had been raised in the previous three years, however, these had not been escalated to the Medical Director or senior management.

Summary of Reports Actions

Recommendations and actions from the RCR and BSBR reports are detailed below.

The Royal College of Radiologists report.

The RCR's recommendations below are classified by urgency/priority.

Action	Priority	QSI[1] standard
Patient safety		
1. Agree a revised approach to list management that maximizes radiograp and imaging capacity and supports patient choice.	Medium	XR-601, XR-501, XR-5(
2. Review out of hours emergency imaging pathways with colleagues fron Emergency Department to ensure alignment with current standards an benchmarks, and ensure the revised pathways are consistently adopte	Medium	XR-206
3. Explore the scope to run a restricted access pilot of a one-stop breast c supported by the advanced practice radiographer, and audit the impac waiting times for patients with concerns about their breast health.	Medium	XR-601
4. Urgently clarify plans for the continuation of the Interventional Radiolo (IR) service on Jersey.	High	XR-802, XR-804
Service planning and delivery		
5. Explore alternative approaches to producing rotas and managing lists i way that makes best use of machine, radiographer and radiologist capa Consider the use of in-sourcing and out-sourcing to manage excess rep demand, and the conditions for deployment of these options.	Medium	XR-601
6. Urgently review and expedite business cases for replacement/additiona equipment in CT, MRI, mammography and IR.	High	XR-302
Service planning and delivery		
7. The Clinical Lead and Superintendent Radiographer should work togeth and with their teams to develop a future vision and shared goals for the service and its staff.	High	XR-201
8. Communication and cohesive team working needs to be developed am the radiographic and radiology teams, demonstrating mutual respect a	Medium	XR-208

[1] Royal College of Radiologists Quality Standards for Imaging

	professional courtesy, with clinical effectiveness, governance and quali improvement offering a focus for these efforts.		
9.	Radiologists should reflect carefully on their interactions with colleague outside of the department (including foundation doctors and clinical fe to ensure they preserve civility.	Medium	XR-208
Clinical governance			
10.	Document the governance framework, clarifying reporting lines, responsibilities, accountabilities, and routes for escalation and support re-setting expectations around sharing of audit outcomes and actions.	Medium	XR-7
11.	Further develop REALMs as creative learning opportunities for radiolog and reporting radiographers alike.	Medium	XR-704
12.	Consider strengthening the Clinical Lead role by developing it into a Cli Director role, clarifying accountability for the quality of patient care, an responsibility for setting behavioural and professional standards.	High	XR-201
13.	Ensure that the Clinical Lead is supported in accessing appropriate professional support in his new role.	Medium	XR-208
Managing concerns			
14.	Carefully review and act on the recommendations made in the confide appendix to this report.	High	XR-208
15.	Review how processes for raising and responding to concerns are documented and ensure that all staff with professional leadership and management responsibilities understand how to respond to and docun such cases, and how to communicate appropriately with colleagues wh directly or indirectly impacted.	High	XR-701, XR-208

The British Society of Breast Radiologists Report.

The BSBR report concluded as follows:

The Radiologist

1. We conclude that the radiologist should no longer be involved in screen reading, surveillance/family history mammography reading, screening assessment clinics or wire localisations.

2. We have no clear evidence that the radiologist should not continue doing symptomatic breast work. However, if they continue to image symptomatic patients their work should be closely audited, and they should attend a breast multi-disciplinary update course at one of the UK training centers.

Recall of patients seen.

1. Patients who have had their **screening mammograms** read by the radiologist have also had them read by another film reader as a matter of routine. There is no suggestion of poor performance by other members of the breast imaging team. **Therefore, recall of these women is not required.**

2. Women who have had their screening assessment performed by the radiologist are routinely given a 12 month follow up appointment. Given the length of time the radiologist has been suspended from breast work, all these women will either have been seen or will be seen as planned in the next few months.

3. Women who have had their post treatment, surveillance mammograms read are routinely re-imaged 12 months later. Given the length of time the radiologist has been suspended from the breast work, all these women will either have been seen or will be seen as planned in the next few months.

4. Women who have presented with symptoms will have had a clinical examination and an ultrasound scan performed by the surgeon in addition to imaging read by the radiologist, so the scope for missed cancers is low. Missed cancers from symptomatic clinics usually re-present within 12 months and it will soon be 12 months since the radiologist last imaged women with breast symptoms.

Mammography Unit recommendations.

1. There should be an urgent multidisciplinary QA visit to assess the screening programme in its' entirety. This must include programme management, routine data collection and audit.

2. Symptomatic one-stop breast clinics should be instituted, where the surgeon and radiologist are co-located and work together.

3. MDT function should be externally assessed.

4. Equipment:

    a. The current digital mammogram (DM) unit is old, and the images are poor. It should be replaced as a matter of urgency.
    b. Any second DM unit should be co-located with clinical and ultrasound rooms to enable one-stop clinics to take place.
    c. Replacement and new DM units should be DBT biopsy and contrast mammography ready.

5. Serious consideration should be given to having a radiographer advanced practitioner as breast imaging lead to improve management of the unit.

Duty of Candour recommendations following the BSBR review

We have identified six cases in (our review) in which there has been a significant delay in diagnosis, warranting a duty of candour discussion. In most of these cases, either more than one individual or the MDT as a whole was responsible for the delay in diagnosis.

Medical Directors Office Actions & Recommendations

The Review / Recall of Patients

The BSBR team was asked to determine whether a patient recall was necessary. They determined that a patient recall was not necessary, and set out their thinking in their conclusions (see above). However, whilst the BSBR team noted that patients would pass through the system "in the next few months" it would in fact be 5 months before all the relevant patients had passed back through the system.

This is a relatively long period of time, and the HCS view was that it was not acceptable that we allow these patients to simply return as normal over the next few months. HCS therefore decided to undertake a rapid review of all the radiologist's patients and to recall any where a recall was felt to be necessary.

From August 2019 to September 2023 the radiologist concerned had read the results of 3,467 patients. Of these, 669 patients had already been rescreened and read by another radiologist - leaving 2,798 patients to review.

The key findings from the review of this patient cohort were as follows:

Total number of patients reviewed:	2,798
Total number of patients recalled for further tests:	23
Total number of patients identified with "delayed diagnosis":	14

The review identified 23 patients who HCS felt it was appropriate to recall for further tests. 3 patients had already been rescreened during the course of the recall period and had had normal mammograms. This left 20 patients to recall.

The review also identified 14 patients where we discovered a delay in their diagnosis and where our duty of candour meant it was right for us to inform them of this.

It was made clear to patients being recalled – and made clear to the media – that they were not being recalled because an abnormality has definitely been missed. They would have been offered a further mammogram anyway, and were simply being recalled early as a precautionary check of their earlier imaging.

The patients who may have had a delayed diagnosis were already aware of their personal diagnosis and were as a result of the review process being informed of the fact there may have been a delay in that diagnosis.

All the patients being recalled and all the patients who have had a delayed diagnosis were notified once the review had been completed, and before any public announcement was made. The patients being recalled were all seen withing a time frame that suited their availability. Patients were telephoned to inform them of their recall, and offered a choice of appointments, including in additional clinics that had been arranged in order to be able to provide a choice of appointments

quickly. Patients who had a delayed diagnosis were telephoned and offered an appointment with a consultant, to provide additional information and offer support.

The summary of recall results will be made public once all results have been received and patients informed. This is anticipated to be before the end of July 2024.

Communications

During the course of our interaction with the Royal College of Radiologists (RCR) and subsequently the British Society of Breast Radiologists (BSBR) communication was kept closely within the Medical Directors office, the Mammography Unit and the HCS Chief Officer. This was to enable HCS to properly examine whether this was a significant issue and whether there would be a need for a patient recall.

In fact, following review by the BSBR, their recommendation was that a recall of patients was not required. However, for the reasons described above the decision was taken to conduct a review and recall.

Once the total number of patients requiring review of their mammograms had been determined, both the Minister and the HCS Advisory Board were informed (in April 2024).

The NHS National Quality Board guidance on patient recalls notes that patients may be "anxious during the recall process". It also says, "It can be potentially stressful for a patient when they are recalled for a review of their care or treatment, therefore ensuring that you do not include patients unnecessarily is important."

It is for this reason that widely accepted good communication practice is to identify those patients that need to be recalled as rapidly as possible and to communicate directly with them before communicating more widely. This ensures the maximum level of public reassurance and minimises the level of unnecessary public anxiety.

It is important to note that our communication plan was to ensure that if any Jersey patient was concerned about their mammogram and they had not heard from HCS at the time of the public announcement, they could be reassured that this issue did not affect them.

Once all the relevant patients had been contacted – in the interests of transparency and reassurance – HCS then briefed the media and facilitated interviews with both the Minister and the Deputy Medical Director.

The Mammography Unit

The RCR and BSBR review teams both reference problems in the Mammography Unit, including governance and multidisciplinary team meetings (MDT).

The BSBR review notes:

"The problems described above have been compounded by a lack of action when issues were repeatedly raised. This lack of leadership may have been partly secondary to close interpersonal relationships……, such that performance issues were not addressed. This resulted in considerable mental stress on those raising concerns, which could have been avoided. The delay in action has also had an impact on the radiologist and the general functioning of the Unit, as the loss of confidence in him and governance of the unit could have been minimised if the issues had been addressed promptly. We believe this is now irredeemable.
The above scenario appears to be symptomatic of a wider lack of management and inadequate communication."

The Mammography Unit and Radiology department moving forward

Both the RCR and the BSBR reports make recommendations for the future conduct of the mammography service in Jersey. These are included above.

We recommend that the RCR and BSBR recommendations should be adopted in full.
The new Clinical Lead should attend a suitable off-island leadership course and be supported to do so. Time must be given up in their job plan, together with the superintendent radiographer as detailed in the action plan.

Breast services in the whole within Jersey should link with a parent unit in the mainland. The MDT should align with that unit in a manner that both units recognise as workable and acceptable to both parties.

Conclusion

A number of significant issues and concerns were raised in both the RCR and BSBR reports. These pertain to a range of patient safety, service delivery, governance and 'raising concerns' factors. Leadership and culture are also identified as areas for further improvement; this is consistent with fundings in other reviews across HCS.

HCS must ensure that the new lead is supported in gaining thorough leadership training and supported in becoming a clinical director, as recommended by the RCR. As such HCS should fulfil all the recommendations laid out in the RCR report in relation to that role and be supported to do so.

HCS must ensure that governance structures in radiology are strengthened, supported, and monitored. Consideration and support should be given to the recommendations made by the BSBR as to leadership of the mammography unit. The mammography unit must link to a suitable UK unit.

HCS should begin a programme similar to those being undertaken in maternity and medicine to ensure the above actions are carried through. This will require weekly meetings with the radiology lead, the superintendent radiographer and, the surgical care group and senior management to ensure the actions are embedded and realised. This will require resource and support. It will also require cultural change.

HCS must continue to ensure that staff feel empowered to speak up and be heard and supported to do so and HCS should consider how this matter can be used to inform learning across the whole organisation. It is also accepted that the findings here are similar to those in other departments within HCS and support the conclusions of the 2022 Review of Governance.

The Medical Director and Deputy Medical Director will continue to take all concerns seriously, to commission reviews, including patient recall where necessary, and to identify improvement plans as required.

For Mammography, the results from the patient recall are expected to be received imminently, and will be reported publicly once all patients have been informed.

This incident requires discussion with the HCS Advisory Board and Minister for Health & Social Services.

Simon West MB BCh, FRCS (Edin), FRCS (Tr & Orth)
Deputy Medical Director.

Patrick Armstrong FRCS (Tr & Orth), MBE
Medical Director.

Report of the invited review of the radiology department at Jersey General Hospital

17 & 18 January 2024

The Royal College of Radiologists

Contents

Table of abbreviations

The report contains a number of abbreviations and acronyms; for the ease of the reader, these are spelt out in the table below.

Term	Definition
AAU	Acute Assessment Unit
CT	Computerised Tomography Scan
ED	Emergency Department
FRQA	Film Reader Quality Assurance
GIRFT	Getting It Right First Time
HCS	Health and Community Services, Government of Jersey
IR	Interventional Radiology
MDT	Multi-Disciplinary Team
MRI	Magnetic Resonance Imaging
NICE	National Institute for Health and Care Excellence
POCUS	Point of care ultrasound
RCR	Royal College of Radiologists
REALMs	Radiology Events and Learning Meetings
SIG	Special Interest Group

Service review team

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Head of Professional Practice and Quality Improvement, the Royal College of Radiologists.

Executive summary

Introduction

This report presents the key findings from the Royal College of Radiologists' review of the radiology department at Jersey General Hospital. This summary and the subsequent report complement the verbal feedback given at the end of the review visit and the initial letter sent on 30 January 2024.

The invitation to undertake a review arose specifically in connection with the breast screening service, but with the agreement of senior managers the review considered the radiology department in its entirety, with specific reference to the effectiveness of service planning and delivery, team working, clinical governance and arrangements for raising and responding to concerns.

The review team observed and heard examples of a range of aspects of good practice in the department over the course of the review visit. Of particular note are the department's reporting turnaround times which, though enviable, do come at the expense of other aspects of effective service planning and delivery and patient care and safety, and require careful consideration by relevant medical and non-medical leaders so that achievable and sustainable improvement plans can be actioned.

Patient safety

The review team identified several aspects of how the department operates currently that give rise to potential patient safety concerns. Specifically:

- An alternative approach to list planning has the potential to maximise radiographer and imaging capacity, support improved patient choice, and impact on waiting times.
- There was some evidence that overly-rigorous gatekeeping of radiology resources, particularly for out of hours emergency imaging, may have led to adverse patient outcomes in some instances.
- The lack of a one-stop breast clinic currently can lead to delays for patients seeking to access support, diagnosis and treatment.
- The provision of an interventional radiology service on the island is essential for patient safety, and future plans for its continuation need to be clarified.

Service planning and delivery

The review team identified two areas in which improvement actions could be taken to enhance the planning and delivery of radiology services, focusing on making best use of capacity, and equipment replacement:

- The Clinical Lead and Superintendent Radiographer need to work collaboratively to explore alternative approaches to producing rotas and managing lists in a way that makes best use of machine, radiographer and radiologist capacity.
- Business cases for replacement of ageing equipment and investment in new equipment in CT, MRI, mammography and IR need to be expedited in the interests of service resilience.

Team working

The review team observed a need for improvements in how the radiology team works together as a cohesive unit:

- The Clinical Lead and Superintendent Radiographer need to develop a constructive and effective relationship and establish shared goals for the service and its staff to ensure effective service delivery.
- The wider staff teams also need to communicate effectively, work cohesively and demonstrate mutual respect and professional courtesy.
- Radiologists, in particular, should ensure that their interactions with wider colleagues outside of the department are civil and professionally appropriate.

Clinical governance

The review team noted the context provided by Professor Hugo Mascie-Taylor's 2022 independent review into clinical governance arrangements within secondary care, and noted the similarities between the issues highlighted in Professor Mascie-Taylor's report and the areas for improvement identified via the invited review:

- The governance framework needs to be documented to clarify reporting lines, responsibilities, accountabilities, and routes for escalation and support.
- There is scope to improve provision of REALMs to ensure they facilitate learning across the whole department – for radiologists and reporting radiographers alike.
- As part of the current review of the Clinical Lead role descriptor, consideration should be given to establishing this as a Clinical Director role, with clear responsibility for setting behavioural and professional expectations, and accountability for the quality of patient care provided by the department.
- Appropriate professional support should be made available to the Clinical Lead to support him in his new role.

Managing concerns

The invitation to the RCR to undertake a service review was triggered as the result of a concern that was raised regarding an individual. The review team sets out further reflections on the management of the concern in question, including actions needed to seek to expedite resolution of the concern, in a confidential appendix to this report that will be provided separately.

More generally, there is an urgent need to review how the processes for raising and responding to concerns about individuals are documented, in relation to both clinical competence and/or professional capability. All staff with professional leadership and management responsibilities, in particular, should understand the recommended ways to:

- respond to and document such cases;
- regularly communicate with and support the individuals that are directly impacted by such concerns being raised; and to
- communicate appropriately with the wider department.

1. Introduction and background

1.1 The Royal College of Radiologists (RCR) undertook an invited review of the radiology department at Jersey General Hospital on 17 and 18 January 2024. The initial request for the review centred around a concern that had been raised regarding the practice of an individual radiologist.

1.2 The RCR is not a regulatory body, and as such does not consider it appropriate to undertake reviews of clinical cases or of individual doctors. The service has been encouraged to engage the relevant Special Interest Group (SIG) in a planned review of relevant cases. The RCR does, however, offer reviews of services as a whole, particularly where it is possible that cultural, systemic or structural barriers exist that may prevent concerns about an individual, identified from audit data, from being raised and from being managed appropriately. The Terms of Reference for the review were established with this in mind and are set out in the next section of this report.

1.3 The review followed the process set out in the RCR's *Service Reviews: Process guidance for clinical oncology and clinical radiology*, dated November 2022. The review was informed by the standards set out in the *Quality Standard for Imaging* (2021), and by relevant guidelines published by the RCR and other appropriate external reference points.

2. Terms of reference

2.1 With the agreement of the Deputy Medical Director, the review examined the following across the department as a whole:

a) **Service planning and delivery:** Review current staffing numbers and skill mix, with reference to the department's ability to discharge its duties in effectively managing current and anticipated workload, including consideration of how workload allocation, monitoring and reporting capacity are understood and planned.

b) **Team working:** Review the multidisciplinary teamworking (MDT) arrangements within the Radiology Department, with a view towards determining that they safeguard the ongoing delivery of safe and effective care, particularly in the context of team dynamics and any interpersonal issues that may arise from time to time.

c) **Clinical governance:** Consider the effectiveness of current governance arrangements, including:

- How Radiology Events and Learning meetings (REALMs) operate – including how they are chaired, how colleagues are encouraged to bring forward cases for inclusion, who attends, how frequently they take place, and how key learning points are shared with those who are unable to participate.
- How learning from discrepancies is disseminated through the service and the hospital as a whole, including between surgery and radiology;
- Understanding the safety and clinical governance culture in place across the hospital, including how issues and concerns are reported and acted upon; and
- Considering the formal clinical governance structure and its operation; and how effectively it supports embedding sound quality management, audit and improvement practice across the organisation. This will include consideration of the current programme of internal audits, and the extent to which their design and delivery effectively supports identification of potential safety issues.

d) **Managing concerns:** Review the effectiveness of the arrangements that are in place for raising and responding to concerns regarding the practice and behaviour of medical/clinical staff in the department.

2.2 The service review did not assess individual performance or competence.

3. Methodology of the review

3.1 Planning for the review began in September 2023. A visit date of 17 and 18 January 2024 was agreed in November 2023 and terms of reference were refreshed and agreed by the hospital senior leadership team and the RCR. A range of contextual documentation was requested by the RCR team and uploaded by the department to a secure cloud site for consideration by the RCR review team in advance of the visit.

Survey

3.2 A confidential online survey link was shared by email six weeks before the visit, and was distributed to staff in the department. Responses were viewed and collated by the RCR and not visible to Jersey staff with oversight of the review. A total of 23 responses were received. The survey asked general questions seeking to establish respondents' views on what worked well in the department, what could be better, and what outcomes they hoped to see as a result of the review. Staff were asked the length of time they had worked in the department, and their generic role.

3.3 The responses were analysed, collated and summarised by the RCR to provide contextual detail to the review team ahead of the visit. Some noticeable differences were noted between the responses of radiologists and radiographic staff, with the latter reflecting a 'them and us' dynamic between the two staff groups, and the former focusing more on external factors that can make staff recruitment challenging – principally around the high cost of living on Jersey. We have used the findings from the survey in drafting this report, although statements have been cross-checked and triangulated to ensure that the views or experiences of one or a small number of individuals have not skewed the conclusions.

Interviews

3.4 Members of the review team were able to attend the weekly radiology team meeting and the breast screening arbitration meeting, which were already scheduled to be taking place at the time of the visit, before meeting together with senior staff in the department to set the context for the visit and hear their views. Subsequently, the review team split into two groups and met with a range of staff with different roles in the department and the wider hospital; role details of those who contributed are listed in Appendix 4. The team was also able to tour the site and speak to a range of staff in situ. Staff were assured of confidentiality and appeared to feel comfortable talking to the reviewers.

3.5 The final timetable for the review broadly enabled sufficient allocation of time for interviews, and time for collaborative discussions amongst the review team, though some interviews did extend beyond their allotted time. The support provided by the Superintendent Radiographer in setting up the timetable for the visit and the interviews undertaken, and in managing the logistics of room bookings and catering, was much appreciated.

Feedback and reporting

3.6 Verbal feedback was provided to the Deputy Medical Director, Surgical Care Group Director, Clinical Lead for Radiology, Mammography Lead, Superintendent Radiographer and other colleagues in the department who had been invited to hear the review team's initial findings at the end of the two-day visit.

3.7 A letter outlining the review team's initial findings was sent to the Deputy Medical Director on 30 January 2024, along with a separate confidential appendix setting out further reflections on the

management of the concern that triggered the initial request for a review. As noted in paragraphs 1.2 and 2.2 above, consideration of matters of individual clinical practice and competence lies outwith the remit of the RCR and the terms of reference for this review; nonetheless the review team outlines its thinking and recommendations in the interests of expediting resolution of the concern in question for the benefit of all concerned.

3.8 The Deputy Medical Director was provided with a draft of this report and offered the opportunity to raise any matters of factual inaccuracy prior to the report being finalised.

4. Service review findings

The review team's findings are set out under the broad headings of the terms of reference.

4.1 Service planning and delivery

Capacity planning

4.1.1 The review team heard that the department operates a system whereby radiology lists are 'owned' by an individual consultant, which is intended to ensure that any imaging undertaken in a session is reported by that consultant, usually on the same or next day. Whilst this approach results in impressive turnaround times on image reporting, it risks exacerbating waiting lists, whereas a standardised list with shared reporting may improve throughput and support more equitable allocation of work. The current approach also risks limiting patient choice according to their condition and the areas of specialism of the radiologist who is running the list on a given session. The team also heard reports of delays in confirming rotas which, in turn, impact on the appointment booking and confirmation process; this was reported to be a particular issue in CT.

4.1.2 Multiple members of the radiology staff team outlined the work done recently, with specific additional short-term funding, to reduce MRI waiting lists to three weeks for public patients and two weeks for private patients by running additional lists. By 22 December 23 the public waiting time was seven weeks. However, it was reported that since funding for this initiative came to an end, the waiting time has risen back to twelve weeks. Similar waiting list issues exist in CT, and the current approach to planning lists has prevented more creative options for maximising radiographer and scanner capacity from being meaningfully explored. The second CT scanner is not being run to capacity, despite being staffed by locums, until a sustainable approach to managing reporting workload can be agreed.

4.1.3 A number of radiologists with whom the review team spoke argued that the current approach, which ensures ownership of lists and enables swift reporting turnaround, prevents patients' imaging from sitting unreported in a worklist and so reduces the risk of patients coming to harm. Consideration must, though, be given to the time that other patients remain on waiting lists as a result of this approach to service planning, and whether this presents a greater or lesser degree of risk to patient safety. There is willingness on the part of radiographers to scan to capacity if a system can be put in place to manage 'excess' reporting carefully in a way that everyone understands and supports.

4.1.4 The review team heard that work was undertaken four to five years ago to standardise imaging protocols, though it was acknowledged that there may have been drift over time – including towards individual consultants' preferences for the particular lists they run. Whilst this is viewed as a means of controlling quality, it may be beneficial to revisit the current suite of protocols to ensure consistency for radiographic staff.

4.1.5 The review team noted the deficit of funding for services in HCS, and the need therefore to look creatively at alternative approaches to managing and improving throughput – both inpatients and outpatients – in ways that are sustainable and affordable in the longer term. This might include reconsidering how maximum use can be made of reporting radiographers operating at the top of their licence, though it is acknowledged that this will require appropriate backfill for their image acquisition responsibilities, and that recruitment – particularly to lower graded roles – is challenging in light of the high cost of living on Jersey. It was noted that the primary area in which unfilled vacancies are presenting a particular challenge is in ultrasound.

Alternative approaches to engaging with outsourcing are also being explored via the Care Group.

4.1.6 There are differences of opinion regarding the primary barriers to increasing service capacity: one view is that the approach to managing lists makes effective use of radiologist reporting capacity but leaves radiographer and machine capacity unused. It is unclear whether this approach makes best use of the radiographic workforce, particularly from a skills escalator perspective. The alternative view is that radiology is adequately staffed, with insourcing and teleradiology available to cope with peaks in demand, but that a) a lack of radiographers prevents the department from bringing waiting times down, and b) there are not sufficient offices or reporting workstations to be able to recruit any more radiologists as an addition to the single vacant radiologist post. An office is currently available for the vacancy, currently covered by a locum. The review team also heard about the challenges in recruiting good generalist radiologists who also have a range of subspecialty interests, and whilst the extent to which this presents specific service delivery issues was not clear, the team welcomed the ways in which the Clinical Lead is exploring scope for radiologists to have dedicated time in their job plans to be able to attend MDT meetings at associated tertiary centres at least once per month as a means of continuing to build and maintain competence in specialist areas. From an IR perspective, mentorship and other measures to support sustainable stroke thrombectomy provision are also being considered.

4.1.7 There is no single, correct way to plan service delivery, but there is a clear need to more systematically explore the available options. The RCR's Radiology Reporting Figures for Service Planning (2022) presents the key factors for consideration in relation to the increasing complexity of reporting that radiologists are expected to undertake alongside patient management responsibilities, and the expectations associated with different reporting environments. It may also be beneficial to consider the recent Homeworking for Radiologists (2023) guidance.

4.1.8 The Clinical Lead and Superintendent Radiographer need to work collaboratively to explore alternative approaches to producing rotas and managing lists in a way that makes best use of machine, radiographer and radiologist capacity, and is transparent to the wider department. This may include increased use of in-sourcing and out-sourcing arrangements, and agreement of the conditions under which either or both of these options might be deployed. It is recognised that a reduction in the time period during which a patient is waiting to undergo an imaging examination may come at the expense of an increase in the time period between image acquisition and the examination being reported, but there is nonetheless scope to increase reporting turnaround times whilst remaining well within the norms that are accepted elsewhere (e.g. NHS England diagnostic imaging turnaround times).

4.1.9 In addition, it was noted that the mammography service does not currently offer a one-stop symptomatic clinic. Surgeons currently undertake ultrasound as an extension of their clinical examination, and anything more complex requires a separate booked appointment. Whilst it may not be feasible to offer this service to all symptomatic patients, the team is encouraged to explore what might be offered within existing resources such that patients with concerns about their breast health may avoid delays in accessing support, diagnosis and treatment. The service benefits from the expertise and experience of an advanced practice radiographer, who has the potential to develop towards a consultant radiographer role, and would be well placed to lead such a clinic. Consideration might be given to undertaking a restricted access pilot (e.g. limited to those patients with an examination score of P3 and above).

4.1.10 The newly-appointed Clinical Lead is also the IR lead for the service, and the review team heard the challenges that have arisen in providing good service continuity in the context of staff sickness absence and turnover. There are aspirations to build IR provision on the island, though the need to replace equipment that has come to the end of its life and recruit and/or train staff in IR present significant barriers to realising that ambition. In the absence of local provision, arrangements are in place for patients to be treated at tertiary centres on the UK mainland, though the financial argument for doing so in preference to developing services on Jersey was not clear. Continuation of the service is essential for patient safety. Therefore plans require urgent clarification: the absence of such clarification will have repercussions both for surgery, and for the wider radiology department, risking destabilisation of the service; see Provision of Interventional Radiology Services (2019).

Equipment replacement

4.1.11 The review team heard that, on the whole, the planning of equipment replacement works well, with all equipment usually being replaced at the ten-year mark at the latest (seven years for ultrasound). Staff reported that unplanned downtime on the current CT and MRI scanners has led to disruptions in service provision, although the maintenance and support service contract that is in place generally results in swift issue resolution.

4.1.12 It was also noted that the current mammography machine, whilst tomosynthesis and contrast-enhanced enabled, is ten years old and requires replacement, and an additional machine is also required to facilitate expanded capacity. Once this is available, the service will be able to move to 'opt out' rather than 'opt in' provision of screening. The age of the current machine was cited by more than one staff member as a factor in errors occurring, specifically in relation to calibration of stereotactic wire placement.

4.1.13 Staff explained the process for making a business case for capital replacement, which they described as 'straightforward'. Proposals for investment in more modern equipment to replace ageing machines and to support service expansion are currently under consideration, should be urgently reviewed and expedited where possible to ensure the resilience of the service.

4.2 Team working

4.2.1 The review team was able to meet with a range of staff across the department over the course of their two days on site, both in individual interviews and through attendance at regular departmental meetings. This included an opportunity to attend the weekly breast screening arbitration meeting, which was observed as a collaborative forum in which participants had an equal voice, although some suggestions to the contrary were among the comments made by respondents to the pre-review survey.

4.2.2 A number of staff members specifically noted the quality of support available to them from the Superintendent Radiographer, which has been especially valuable where colleagues are managing multiple demands and covering for vacant roles. Radiographic staff welcome the opportunities and support available to develop as advanced practitioners.

4.2.3 The review team observed that there was a need for multifaceted improvement in how the radiology team works together as a cohesive unit – at department level and in how the radiology department supports other clinical areas in the hospital. The survey undertaken prior to the review suggested a 'them and us' culture between radiologists and radiographic staff, though also the potential for the small scale of the department (when compared to typical

departments in the NHS in England) to promote greater team working and patient focus. This was borne out in the interviews undertaken during the review.

Radiology leadership team

4.2.4 There was some evidence that the relationship between the Superintendent Radiographer and the outgoing Clinical Lead was not as constructive as it needed to be. For example, the Terms of Reference for the RCR review were agreed among the senior medical team in November 2023, but it appears that the scope of the review and expectations around submission of documentation and planning were not communicated to the Superintendent Radiographer or other staff in the department until December.

4.2.5 There was agreement that the relationship between the Superintendent Radiographer and the Clinical Lead for Radiology is an important one, and the appointment of a new Clinical Lead provides an opportunity to reset this. A constructive and effective relationship between the Clinical Lead and Superintendent Radiographer, that includes shared goals for the service and its staff and demonstrable collaborative working, is key in effective service delivery. The Superintendent Radiographer and the Clinical Lead for Radiology require active support and time to work together to create a shared vision for the future of the department and its unified leadership, and to work with their teams to understand how that vision might best be achieved.

4.2.6 A number of the staff that the review team met suggested they would welcome a resetting of the team ethos that it was reported had been characteristic of the department in the past. Learning and developing as a group of radiologists and radiographers – for example, through study days, 'lunch and learn' sessions, or REALMs (see paragraph 4.3.5-4.3.8) – may offer a vehicle for this, in addition to more regular attendance by all at the regular departmental meetings that are held such that these can develop as a forum for shared problem solving. Strong departmental leadership was cited as the factor that is likely to make the greatest difference to enabling the team to work in a more mutually supportive way.

Wider radiology staff team

4.2.7 A view was expressed by some individuals with whom the team met that the 'social glue' that unites the workforce around a shared focus on improvement was, perhaps, lacking – though conversely the review team also heard a consistent message from multiple review participants that their primary driving force was a commitment to providing an excellent service to the population of Jersey. The desire to provide good continuity of care for the population served was a consistent theme throughout the review visit.

4.2.8 It was clear to the review team that the wider staff teams of radiographers and radiologists in the department need to communicate effectively and work cohesively, demonstrating mutual respect and professional courtesy. The visiting team heard multiple, specific examples of communications between radiologists and radiographers that they would not consider to meet basic expectations regarding civility and professional respect, based on what was described. The Clinical Lead, in particular, has an important role to play in modelling appropriate professional behaviours and ensuring that expectations are upheld among the wider team of radiologists (see paragraph 4.3.9).

4.2.9 A commitment to attending and actively engaging in relevant cross-departmental meetings by radiologists will be an important start, though other approaches that enable shared

engagement in issues of clinical effectiveness, governance and quality improvement should be explored, including reviewing leadership responsibilities for these areas.

Colleagues outside of radiology

4.2.10 Interdepartmental relationships, and expectations around the level of service that radiology should provide to acute specialties, are complex. The review team heard multiple reports of 'rough treatment' of junior doctors from AAU and ED when they come to radiology with requests for imaging. There is, of course, an expectation that radiology will vet all requests made to ensure they are clinically appropriate, but the review team was concerned that this appears to be being done without due regard to professional courtesy and civility. There are also knock-on effects for Emergency Medicine clinicians who are seeking to diagnose acute cases and manage bed occupancy if imaging is not undertaken when requested or in a timely manner. Particular concerns were raised regarding rejection of requests for CT heads, which in other settings would be justified under NICE guidelines, and the associated risks to patient safety.

4.2.11 Concerns were flagged regarding the perceived inappropriate response that some radiologists have given to imaging requests made by junior doctors. It is accepted that sometimes a less experienced medic may provide insufficient information on an imaging request, and it was suggested that the face-to-face conversations that the radiology team insist upon when considering such requests should offer an opportunity for a professional discussion. Concern was expressed that behaviour is sometimes so aggressive that the experience of exchanges of this kind may lead to changes in a doctor's clinical judgement over time, such that they opt not to request a scan (to avoid confrontation) and that this subsequently leads to adverse outcomes for patients.

4.2.12 The team heard that an organisation-wide Civility Saves Lives programme is underway, and it is essential that radiology staff engage meaningfully with this. Radiologists, in particular, should reflect carefully on the ways in which they interact with the wider team of colleagues outside of the department – including foundation doctors and clinical fellows. In particular, there is a need to ensure that approaches to gatekeeping access to scarce imaging resources preserve civility and ensure that foundation doctors and others gain a positive impression and experience of radiology that they take forward into their future careers. Electronic requesting and vetting procedures should also continue to be explored, including consideration of iRefer.

4.2.13 The trauma pathway that is in place was reviewed and agreed in the recent past, and the radiologists have agreed CT criteria for major trauma. However, it was reported that adherence to the agreed pathway is variable. Case examples were provided that illustrated this point. It was noted that the Cauda Equina MRI pathway is currently being finalised with the streamlined diagnostic criteria published by GIRFT being incorporated. No specific concerns were reported in relation to plain film or ultrasound requests from ED; with respect to the latter, most doctors in ED are now POCUS-trained.

4.2.14 It was noted that the civil service contractual agreement under which radiographers work does not oblige them to be on call. As such, any on call radiographer service is provided via the goodwill of the staff member concerned. At weekends on call cover is typically provided by one radiographer, but if that staff member is engaged in theatre for orthopaedic procedures, this results in either no cover, or gaps in cover, for ED and trauma imaging. The review team

received assurances that whilst this has been a clinical issue whereby patients have had to wait longer for imaging, it has not so far been a clinical safety issue.

4.2.15 Some participants indicated that they respected the radiology department's stance on protecting access to scarce imaging resources, and that overall their relationship with radiology worked well. This was the minority view among those that participated in interviews with the visiting team.

4.3 Clinical governance

4.3.1 The Terms of Reference for the RCR's review reflected, at a departmental level, similar themes to those addressed in Professor Hugo Mascie-Taylor's 2022 independent review into clinical governance arrangements within secondary care on Jersey, which was commissioned by the Director General of HCS of the Government of Jersey. The report looked at, amongst other things, failure to fully investigate incidents and learn from them, approaches to safety management and governance, multi-professional multi-disciplinary working, and lack of clarity regarding the Clinical Lead role. Work is ongoing in a number of areas, via a change team appointed by the Chief Executive and Chief Minister, to seek to address Professor Mascie-Taylor's recommendations, and the RCR welcomes the request to undertake a review as evidence of an openness to learning from external perspectives. The team also noted that consideration is being given to a GIRFT review of radiology in the near future.

Implementation of clinical governance

4.3.2 At Care Group level, regular INSET days have been introduced to provide opportunities for staff to focus on governance, quality and safety, as well as to develop areas requiring improvement (for example, aspects of the patient experience highlighted via complaints) and to celebrate areas of excellence. Other fora exist for Clinical Leads to come together with senior leaders, including the Medical Staff Committee, Clinical Leads Summits and monthly Clinical Action Group, though engagement was reported as having been patchy at best.

4.3.3 The review team heard about work that has been ongoing over a number of years to embed audit across the imaging modalities, with support from the Radiology Governance Co-ordinator. However, the team also observed that a lack of meaningful data from the systems that are currently in place (e.g. in breast screening there is no equivalent to FRQA as a means of readily reviewing and benchmarking the missed cancer rate for the individual readers); this hampers audit activities, with staff often maintaining their own manually compiled records.

4.3.4 Whilst administrative oversight of the data collection, audit and discussion activities exists, expectations need to be re-set regarding the role that different members of the team should play in upholding clinical governance standards in different fora. Specifically, there is a need to document the governance framework, and to clarify reporting lines, responsibilities, accountabilities, and routes for escalation and support. This should include documenting a clear programme of audits that confirms the purpose, frequency and responsibility for each, and clarifying radiologists' responsibilities towards taking forward improvement actions (e.g. those arising from QSI accreditation). With regard to audit, it was noted that audits undertaken by radiographic staff and by radiologists are not routinely collated together, and this contributes to an incomplete picture of quality and any improvement actions required.

Radiology Events and Learning Meetings (REALMs)

4.3.5 The REALMs are run by the Clinical Lead, and it was noted that the meetings consider a range of cases, with increasing engagement across the department. The Clinical Lead

welcomes the ongoing shift towards a focus on using discrepancies and good spots as the basis for learning. Cases are available to staff in the department to review at any time if they are unable to attend the meeting.

4.3.6 The Clinical Lead is also keen to support staff in building on the relationships that are in place with sub-specialties in tertiary centres, including through engagement with their MDTs and REALMs where feasible.

4.3.7 Radiographic staff do not always have the capacity to attend REALMs meetings, though it would be beneficial to continue to explore how their engagement can be supported. Consideration has been given to running a separate plain film REALMs meeting to provide these colleagues with the opportunity to share both discrepancies and excellent spots for discussion with the wider team on a regular basis, in line with the RCR's REALMs guidance.

4.3.8 For mammography, cases picked up by one rather than two readers might be considered for inclusion as good spots in REALMs, and could be shared routinely with reporting mammographers as a team learning exercise.

Clinical Lead role

4.3.9 It was noted that a review of role descriptions for Clinical Leads is underway. The review is a response to Professor Mascie-Taylor's recommendations to ensure that a clearer structure is in place for such roles, to include sufficient time within a formal job plan to deliver on the agreed service leadership responsibilities. Professor Mascie-Taylor observed a lack of clarity regarding the responsibilities and accountability the Clinical Lead holds with respect to patient safety, with post-holders seeing themselves principally as a point of liaison between their colleagues and the management team, rather than as leaders and managers of clinical services in their own right. The review team heard that the principal barrier to concluding this review of roles and job plans is a financial one.

4.3.10 The current and former Clinical Leads described their roles in signing off leave and considering Datixes, but it was not clear that clinical responsibility rests with the Clinical Lead should something go wrong within the department. This requires urgent clarification. Consideration should also be given to identifying a Deputy Clinical Lead/Director in the event of the current postholder's absence to ensure continuity of support for the Superintendent Radiographer and the radiographic team.

4.3.11 The review team also observed that whilst the Clinical Lead has a good understanding of the current reporting turnaround times for the department, more regular access to and review of other measures such as waiting times and financial performance would support the effective leadership of the department, though it is acknowledged that routine and automated access to reliable data continues to be a challenge (see paragraph 4.3.3). Waiting lists are regularly discussed at departmental meetings, though it was suggested that more could be done in time to develop business intelligence dashboards to support these conversations.

Professional support for the Clinical Lead

4.3.12 The Clinical Lead took up his role in January 2024, shortly prior to the review visit taking place, and set out his ambitions for the evolution of the service for the review team's benefit. In the context of the challenges noted above (see paragraph 4.1.10) in relation to rebuilding the IR service, which can eat into the time in the Clinical Lead's job plan for his leadership and management responsibilities, and considering the work that the Clinical Lead will need to

move forward in relation to the recommendations made through the service review process, the review team was concerned to ensure that he has access to appropriate and ongoing professional support in his new role. The Clinical Lead has good personal and professional networks; nonetheless, the RCR would be happy to facilitate an introduction to its Clinical Directors' Network, and if desired, can endeavour to source an experienced Clinical Director to work with the Clinical Lead as a mentor. Mentoring might also be sought from existing links with tertiary centres, although this may be more suitable for clinical skills development rather than the interpersonal/human factors aspects of leading a service.

4.4 Managing concerns

4.4.1 The Medical Director contacted the RCR in September 2023 with a request to undertake a review following concerns having been raised with the Deputy Medical Director during August 2023.

4.4.2 Review participants reported a perceived lack of action by the Clinical Lead to address the concerns raised. This appears to have led to a perception of attempts to hide alleged poor practice via a review of the whole department. This view was expressed to the review team by a number of individuals. The lack of action has meant that the concerns raised have remained anecdotal with no independent review undertaken to determine whether practice has fallen below an acceptable standard or not. By failing to come to a conclusion, the department has been denied work from a radiologist in a shortage specialty with consequences for the service and its finances. In the process, a great deal of stress has been caused to the individual which could have been avoided. An earlier review could have led to either a return to work or a period of retraining followed by a supervised return to work; either way the issue would be resolved. Some of the radiologists that participated in the invited service review also queried the need for a whole-service review, and similar questions were asked by respondents to the pre-review staff survey.

4.4.3 The review team accepts the complexities that can arise when a complaint of this nature and severity is made, and the hospital's duty of care towards the doctor in question, but it is nonetheless apparent that the current situation presents an opportunity to reflect on the efficacy of the processes that are in place.

4.4.4 Communication has been a particular challenge, particularly in light of the current list booking system which requires those booking appointments to know the nature and volume of imaging examinations they are able to book for the individual doctor concerned. Overall, there is a need to ensure that the right people are given the information they require to be able to make the right decisions.

4.4.5 It was clear from the conversations that the review team engaged in over the course of the review visit that the governance structures that are in place to deal with any concerns promptly and effectively have not been utilised. The team heard, for example, about the work done to harmonise understanding across the Care Group regarding what should be Datixed, and to share key serious incidents and Datixes as a vehicle for learning. It was reported that radiology colleagues have reacted negatively to Datixes logged by other departments (for example, where they feel that requests for imaging have been declined inappropriately), without respect for the referring department's perspective.

4.4.6 Consistent implementation of safety huddles to provide opportunities for any staff member to safely and promptly speak up regarding any concerns is also being considered, learning from

similar practice in theatre. An independent Freedom to Speak Up Guardian has also been appointed.

4.4.7 Aside from the specific concern that triggered the invitation for the service review, the review team heard a number of examples of junior doctors being spoken to inappropriately – more than one person indicated that this was a particular issue for female junior doctors. It was reported that one who challenged one such incident by raising a formal complaint was advised to avoid going to the radiology department in the future.

4.4.8 Overall, the review team agreed that there is a need to re-evaluate how the processes for raising and responding to concerns about individuals are documented, in relation to both clinical competence and/or professional capability. All staff with professional leadership and management responsibilities, in particular, should understand the recommended ways to:

- respond to and document such cases;
- regularly communicate with and support the individuals that are directly impacted by such concerns being raised; and to
- communicate appropriately with the wider department.

5. Conclusions and recommendations

The RCR's recommendations below link to the relevant paragraphs and sections in this report and are classified by urgency/priority.

Action	Priority	QSI standard
Patient safety		
1. Agree a revised approach to list management that maximises radiographer and imaging capacity, and which supports patient choice.	**Medium**	**XR-601, XR-501, XR-508**
2. Review out of hours emergency imaging pathways with colleagues from ED to ensure alignment with current standards and benchmarks, and ensure the revised pathways are consistently adopted.	**Medium**	**XR-206**
3. Explore scope to run a restricted access pilot of a one-stop breast clinic, supported by the advanced practice radiographer, and audit the impact on waiting times for patients with concerns about their breast health.	**Medium**	**XR-601**
4. Urgently clarify plans for the continuation of the IR service on Jersey.	**High**	**XR-802, XR-804**
Service planning and delivery		
5. Explore alternative approaches to producing rotas and managing lists in a way that makes best use of machine, radiographer and radiologist capacity. Consider use of in-sourcing and out-sourcing to manage excess reporting demand, and the conditions for deployment of these options.	**Medium**	**XR-601**
6. Urgently review and expedite business cases for replacement/additional equipment in CT, MRI, mammography and IR.	**High**	**XR-302**
Service planning and delivery		
7. The Clinical Lead and Superintendent Radiographer should work together and with their teams to develop a future vision and shared goals for the service and its staff.	**High**	**XR-201**

8. Communication and cohesive team working needs to be developed among the radiographic and radiology teams, demonstrating mutual respect and professional courtesy, with clinical effectiveness, governance and quality improvement offering a focus for these efforts.	**Medium**	**XR-208**
9. Radiologists should reflect carefully on their interactions with colleagues outside of the department (including foundation doctors and clinical fellows) to ensure they preserve civility.	**Medium**	**XR-208**
Clinical governance		
10. Document the governance framework, clarifying reporting lines, responsibilities, accountabilities, and routes for escalation and support, and re-setting expectations around sharing of audit outcomes and actions.	**Medium**	**XR-7**
11. Further develop REALMs as creative learning opportunities for radiologists and reporting radiographers alike.	**Medium**	**XR-704**
12. Consider strengthening the Clinical Lead role by developing it into a Clinical Director role, clarifying accountability for the quality of patient care, and responsibility for setting behavioural and professional standards.	**High**	**XR-201**
13. Ensure that the Clinical Lead is supported in accessing appropriate professional support in his new role.	**Medium**	**XR-208**
Managing concerns		
14. Carefully review and act on the recommendations made in the confidential appendix to this report.	**High**	**XR-208**
15. Review how processes for raising and responding to concerns are documented, and ensure that all staff with professional leadership and management responsibilities understand how to respond to and document such cases, and how to communicate appropriately with colleagues who are directly or indirectly impacted.	**High**	**XR-701, XR-208**

6. References

British Society of Interventional Radiology (2023). *Provision of Interventional Radiology Services* (3rd edition). BSIR: London.

Clinical Imaging Board (2023). *MRI provision for cauda equina syndrome*. RCR: London.

GIRFT (2023). Spinal surgery: national suspected cauda equina syndrome (CES) pathway.

Mascie-Taylor, H. (2022). Report into clinical governance arrangements within Health and Community Services. States of Jersey.

NHS England (2023). Diagnostic imaging reporting turnaround times.

The College of Radiographers and the Royal College of Radiologists (2021). *Quality Standard for Imaging*. RCR: London.

The Royal College of Radiologists (2023). *Homeworking for radiologists*. RCR: London.

The Royal College of Radiologists (2022). *Service reviews: Process guidance for clinical oncology and clinical radiology*. RCR: London.

The Royal College of Radiologists (2022). *Radiology reporting figures for service planning*. RCR: London.

The Royal College of Radiologists (2020). *Standards for radiology events and learning meetings*. RCR: London.

The Royal College of Radiologists (2020). *Radiology business intelligence for service planning and workforce modelling*. RCR: London.

The Royal College of Radiologists and the British Medical Ultrasound Society (2023). *Recommendations for specialists practising ultrasound independently of radiology departments: safety, governance and education*. RCR: London.

Appendices

Appendix 1: Review team details

Dr Caroline Rubin

Co-Lead Reviewer. Caroline Rubin MBBS MRCP FRCR MA(Ed) is a consultant radiologist with a special interest in breast imaging. She trained in medicine at King's College London and Westminster Hospital Medical School, qualifying in 1979. Appointed consultant radiologist in Southampton in 1988, at the start of the National Screening Programme, she was Director of the Southampton and Salisbury Breast Screening Programme for 25 years and a member of the Advisory Committee for Breast Cancer Screening for 12 years. She has a lifelong interest in education and training and has undertaken many roles including College Tutor for 9 years, Head of Training for 7 years and Head of the Wessex School of Radiology for 5 years.

Roles within the Royal College of Radiologists include Medical Director Education and Training for Clinical Radiology 2013-16 and Vice President for the Faculty of Clinical Radiology 2017-2020.

Dr Matthew Trewhella

Co-Lead Reviewer. Dr Matthew Trewhella BA MBBS FRCR has been a consultant radiologist since 1988, and was the Clinical Director of Radiology to North Tees NHS Trust for 13 years until 2017. He is a former RCR Council member, and was elected to the RCR's Clinical Radiology Faculty Board twice. He has been a member of the RCR Service Review Committee, and has participated in a number of invited service reviews.

Kathryn Taylor

Reviewer. Kathryn Taylor DCR MSc is a consultant breast radiographer and one of the first non-medics nationally to become a director of breast screening. She has over 20 years' experience in breast imaging and a further 20 years in a range of imaging roles. She is chair of the radiography advisory group to the national breast screening programme and in this capacity has updated national practice guidance and advised on national workforce strategy. Promoting careers in breast imaging has included recruitment films for NHS England (NHSE), lecturing and blogging on the NHSE website about personal experiences. She has co-authored a book on mammography practice and teaches both undergraduate and postgraduate radiographers on breast imaging techniques and advanced radiographic practice.

Moira Auchterlonie

Lay Reviewer. Moira Auchterlonie LLB, MA (Hons.), PGDip (Leadership) is a Patient Leader and an experienced Lay Representative and Lay Reviewer. She was on the RCR Lay Network until 2023 on the Clinical Radiology and Clinical Oncology Equivalence Committee and on the RCR Radiotherapy Consent Patient Group. She ran an educational charity for 25 years and her regulatory experience includes the Charity Commission, the General Medical Council, General Osteopathic Council and the Medicines and Healthcare products Regulatory Agency. As an 'objective patient', Moira works with influential national bodies including NHS England, BMA, Healthwatch, National Association for Patient Participation, the Practice Management Network and several global medical companies. A healthcare writer, her recent work includes two Health Select Committee submissions, blogs for GPs and candid views on NHS events. She is currently writing a patient contribution to the

Times Health Commission.

Lucy Horder

RCR Review Manager. **Lucy Horder BA (Hons) MA MSc** is the Head of Professional Practice and Quality Improvement at the Royal College of Radiologists, and is the Review Manager for this review. She joined the RCR in April 2022 and is responsible for the strategic development and delivery of a range of services that support the development of our clinical radiologists and clinical oncologists, and the services and systems in which they work. These include a portfolio of clinical guidelines, the Quality Standards for Imaging (QSI) and Imaging Networks (QSIN), and heading up the College's invited review activity. Lucy has extensive experience of leading and developing accreditation services, both in the UK and internationally. She managed 250 review visits during a fifteen-year period at the British Psychological Society, and has particular experience of supporting providers in their quality improvement endeavours, focusing on the application of learning in clinical practice, and on equipping providers to work consistently well above regulatory thresholds.

Appendix 2 Summary of survey questions and responses

Q1. What is your job role?

Role	Percentage	Number
Radiologist	22%	5
Radiographer	48%	11
Other (please specify):	30%	7
	Answered	23

Q2. Approximately how long have you worked at this hospital?

Duration	Percentage	Number
0-6 months	13%	3
6 months – 2 years	17%	4
2-5 years	13%	3
Over 5 years	57%	13
	Answered	23

Q3. Have you previously worked at a different hospital?

Response	Percentage	Number
Yes	74%	17
No	26%	6
	Answered	23

Q4. What is good/better about working here?
Themes included: the care colleagues in the Surgical Care Group have for the quality of patient care/experience; opportunities for development; being able to make a difference; supportive colleagues/team and community feel; support for staff wellbeing and work-life balance; scope for innovation.

Q5. What is less good/worse about working here?
Themes included: difficulties with communication; staff turnover and absence; leadership deficit; PACS not pulling previous images; rushed MDTs; lack of timely equipment replacement; lack of space for mammography; lack of opportunity to learn from new colleagues' skills; lack of consistent rotas hindering booking process; capacity limited by radiologists; no radiographer-led vetting; lack of opportunity for radiographers to lead service development; lack of standardised imaging protocols (too susceptible to individual consultant radiologist preference); private patients taking precedence over public; lack of electronic referrals; ageing hospital estate; poor IT support; lack of civility, particularly to junior colleagues; recruitment challenges; 'the Jersey way'; radiologist resistance to change; lack of radiologist contribution to or leadership of quality assurance and improvement (e.g. QSI).

Q6. Following the review, what is the outcome you would like to see?
Themes included: break down working in silos towards more inclusive team working (move away

from ‘them and us’); improved clinical leadership across radiographic and radiology teams; better approach to list management and appointment booking; greater accountability; additional posts; less micromanagement; adherence to vetting and referral procedures; more time for MDTs (including prep) and engagement with tertiary centres; introduce specialty trainees; greater focus on patient safety.

Q7. What challenges do you think your service faces, and how do you think things could be improved?
Themes included: Communication; willingness to take responsibility for actions and open discussion when things go wrong; need for clarity around accountability for patient care, coupled with need for clarity around who the radiologists are responsible to and stronger departmental leadership; staff retention and need for additional recruitment; ageing equipment; increasing demand for services; cultural apathy; waiting lists growing; lack of civility/professional respect; lack of local movement on AI deployment; poor response to concerns raised and lack of transparent process; potential health inequality caused by current opt in screening service; need for more systematic approach to supporting radiographer advanced practice.

Q8. Is there anything else the review team should know in advance of the review?
Most responses to this question have been covered in previous responses. Some respondents highlighted the unique context of service delivery in Jersey.

Appendix 3: List of documents supplied by the trust

1. Service planning and delivery

XR-203 Staffing Levels and Skill Mix

- Backup of Radiographer Rota Jan 2023
- Induction Check List (Master)
- JD Business Support Officer
- JD Clinical Lead
- JD Consultant Breast Radiographer
- JD Deputy Superintendent Radiographer
- JD Mammography Assistant Practitioner
- JD Radiology Assistant
- JD Reporting Radiographer Mammography
- JD Specialist Radiographer
- New Starter Induction and Leaver Checklist as at 27.12.23
- non-medical STAFF RECORDS 2024
- Radiographer Rota Jan 2023
- Radiology Organisation Chart 2023
- Reporting Radiographer Breast Screening to July 2025.pdf
- RPS Formal appointment letter AA.AH 2023
- Scope of Practice Mammo AP signed 3.3.22
- Scope of Practice Reporting Radiographer Breast Screening.pdf
- Staff Mandatory Training spreadsheet as at 03.01.24
- XR-205 Agency, Bank and Locum Staff
- AUDIT of Temporary Staff Inductions
- New Starter Induction and Leaver Checklist as at 27.12.23
- XR-206 On-call and Out-of-hours' Working
- Out of Hours Guidance
- XR-508 Imaging Reporting Policy
- Reporting Guidelines
- Extract from Assistants rota Jan 24
- Extract from Radiographer rota Jan 24
- Extract of Radiologist rota Jan 24
- Improvement and development plans 2024
- Radiologist on call rota Jan 2024
- Radiology Budget setting 2024
- Radiology Capacity and Demand 2023
- Radiology Management Report 2022
- Radiology performance stats 2021-2023
- Radiology waiting times by week 2023
- Referral Guidelines for GPs

2. Team working

XR-511 Pathway and Condition-specfic protocols

- AUDIT of Cauda Equina Pathway
- CT Protocols CT1
- CT Protocols CT2
- Health and Safety Procedures
- Mammography Protocols
- MRI Breast QA Protocol v 1.0
- MRI Routine Protocols
- Radiology Guidelines on performing interventional procedures
- Radiology PACS and RIS Procedures
- Ultrasound Scheme of Work v 3.1
- X-ray QA Procedures
- TMC SOP

3. Clinical governance

XR-603 Risk Management

- HCS Serious Incidents as of 18.08.23
- Live Risk Register as at 27.12.23
- POLICY HCS Serious Incident
- STRATEGY GoJ Risk Management

XR-701 QMS

- 2023 SU3 and Transition Assessment Report 7482 Jersey
- 2023 SU3 Maintenance of Accreditation Letter Jersey General Hospital
- Confirmation of maintenance of UKAS accreditation
- MINUTES Assistants Meeting 18.12.23
- MINUTES Breast Screening Steering Meeting Sep2022 Draft
- MINUTES Consultant meeting 06.12.23
- Consultant meeting for RCR
- MINUTES Mammo 26.07.23
- MINUTES Q4 Radiology Senior Management

- MINUTES Radiation Protection Committee
- MINUTES Staff meeting 6.12.23
- Quality Management System v4.1
- Radiology Document Control master list
- XR-703 Audit
- AUDIT of Mammo Biopsy Histology
- AUDIT of Radiation Safety Incidents 2023
- AUDIT of Radiation Safety Incidents
- Audit of Recalled Screening Mammograms
- Audit plan and actions 2023
- Consultant Breast Radiologist Mini Audit Guide Wires 13.09.23
- Reporting Radiographer Breast Lone Calls
- Radiology Reports by person 2021_2023

4. Managing concerns

XR-101 Image Service Information

- CT Scan with Contrast
- General XRay
- Masterlist of Radiology PILs
- MRI Scan Non-Contrast
- Paed General X Ray
- Paed MRI
- Paed Ultrasound
- PIL Mammo Biopsy with aftercare
- PIL Mammo Insertion of radio-opaque marker
- PIL Radiation Safety
- Radiology Patient Information
- Ultrasound General
- XR-104 Respect
- POLICY HCS Consent to Care and Treatment
- POLICY HCS Duty of Candour
- XR-105 Privacy, Dignity and Security
- POLICY HCS Intimate Examination Intimate Care Chaperone
- XR-203 Supporting Staff and Staff Wellbeing
- 2023 Be Heard results
- DATIX feedback 2023
- JCC Picker Report Dec 2022
- Patient Experience Key Information Links

Additional documents (tabled)

- Mascie-Taylor report
- Double reading statistics

Appendix 4: Roles of trust personnel involved in the review

Advanced Practitioner; Mammography Manager
AMD Surgical Care Group
Assistant Practitioner
Clinical Fellow
Clinical Lead, Mammography
Clinical Lead, Radiology
Consultant Radiologists
Consultants
Deputy Mammography Manager
Deputy Medical Director
Governance Coordinator
Lead Radiographer
Locum Consultant Radiologist
Radiographers (in situ)
Reporting Radiographers
Surgical Care Group General Manager
Superintendent Radiographer

The Royal College of Radiologists

Radiology Action Plan.

	Action	Priority	QSI Standard	Actions	Owner	Status	Evidence/Comments.
	Patient safety						
1	Agree a revised approach to list management that maximized radiographer and imaging capacity and support patient choice.	Medium	**XR-601, XR-501, XR-508**	1.Clinical Lead and Superintendent to meet and disucss best options to address action. 2)Meet with care group to look at staffing options for radiographers and radiologists for best and effective use of clinical resource. 3)Agree implementation plan and date	NW/JoanneH/SC/JH		
2	Review out of hours emergency imaging pathways with colleagues from ED to ensure alignment with current standards and benchmarks, and ensure the revised pathways are consistently adopted.	Medium	**XR-206**	Action Plan: 1. To explore the possibility of a pathway for CT head studies to be scanned without referral to a radiologist. We already have engaged with A and E on this issue and have imaging protocols ready to implement as a trial. This is underway. This will lower the disruptions for the on-call Radiologist, and decrease the administration for A and E staff. It will also expedite scanning time for the patient. 2. Discuss with Medical and surgical directors regarding guideline adoption.	NW/JoanneH		
3	Explore scope to run a restricted access pilot of a one-stop breast clinic, supported by the advanced practice radiographer, and audit the impact on waiting times for patients with concerns about their breast health.	Medium	**XR-601**	The breast team will review the recommnedation together with the BSBR recommendation on one stop clinics. Current restraints include an effective space as well as equipment. However, all owners will review the actions and establish feasibility and timeline for introduction of service.	NW/ AC/MS		
4	Urgently clarify plans for the continuation of the IR service on Jersey.	High	**XR-802, XR-804**	The establishment of a properly resourced functional IR service is of paramount importance to the department. Failure to deliver a service is to the detriment of patients in Jersey. Current issues are a reflection lof the age of current equipment that requires immediate replacement. Other constraints are an effective space in which to house modern equipment which is too large to be accomodated in the existing suite. Effective options have been presented to the SLT and costed. This reqjuires an immediate financial solution and in the longer term is indicative of a need for a new clinical premises.	NW/ND/Jham/CT		
	Service planning and delivery						
5	Explore alternative approaches to producing rotas and managing lists in a way that makes best use of machine, radiographer and radiologist capacity. Consider use of insourcing and out-sourcing to manage excess reporting demand, and the conditions for deployment of these options.	Medium	XR-601	The Clinical Lead and Superintendent radiographer will review work patterns for both radiologists and radiogrphers to ensure the most efficient use of time to deliver maximum capacity in an effective manner.	JoanneH/NW		
6	Urgently review and expedite business cases for replacement/additional equipment in CT, MRI, mammography and IR.	High	XR-302	Mammography equipment PO for both EQ/JGH has been approved CT still within service contract and in life cycle. MRI still within service contract and life cycle. IR see above	NW/JoanneH/JH		
7	The Clinical Lead and Superintendent Radiographer should work together and with their teams to develop a future vision and shared goals for the service and its staff.	High	**XR-201**	Protected time for the clinical lead and the radiographer will be accommodated and this will be addressed by the clinical lead and the lead radiographer.	NW/ JoanneH		
8	Communication and cohesive team working needs to be developed among the radiographic and radiology teams, demonstrating mutual respect and professional courtesy, with clinical effectiveness, governance and quality improvement offering a focus for these efforts.	Medium	**XR-208**	The department already has regular departmental meeting- Senior management team meeting (all modality managers and clinical lead) all radiologists invited. Whole team weekly meetings ALL invited. These need to be strengthened and an open culture promoted within the department. Attendance by both radiograhic colleagues and radiologists needs to be encouraged and monitored. Feedback sessions will be introduced to allow issues to be highlighted early and any differences percieved or real to be resolved.	NW/ JoanneH		
9	Radiologists should reflect carefully on their interactions with colleagues outside of the department (including foundation doctors and clinical fellows) to ensure they preserve civility.	Medium	**XR-208**	The department engages regularly with 360 degree fedback sessions on an individual basis and was unaware of any concerns relating to specific individuals. Feedback scores are good and relationships were felt to be good. However the department will reflect and engage with any cultural work that may be required to ensure all service users are comfortable.	NW/ND/AC/CH/SZ/SW		
	Clinical governance						
10	Document the governance framework, clarifying reporting lines, responsibilities, accountabilities, and routes for escalation and support, and re-setting expectations around sharing of audit outcomes and actions.	Medium	**XR-7**	The department will ensure the governanee lead engages with the surgical care group governance process. To ensure governance structures are robust and lines of accountability are certain the Surgical Care group will report on governance issues specific to radiology at their Governance reviews. The utilisation of REALMS and PERFORMS will be fed into the Surgicla care group reviews to ensure prompt reporting and maintain a record of trends.	NW		
11	Further develop REALMs as creative learning opportunities for radiologists and reporting radiographers alike.	Medium	**XR- 704**	Folders for REALM cases have been created and offer a learning opportunity on the new PACS. Regular reporting will be recorded.	NW		
12	Consider strengthening the Clinical Lead role by developing it into a Clinical Director role, clarifying accountability for the quality of patient care, and responsibility for setting behavioral and professional standards.	High	**XR-201**	The recognition of the work required to support the clinical lead as a clinical director is agreed and will be supported by the SLT. The clinical Lead should attend a relevant leadship course and ensure regular engagement with the senior radiographer. They will be required to report on a weekly basis to the care group lead for surgery to identify issues early and ensure these can be addressed	NW/ JH/SC		
13	Ensure that the Clinical Lead is supported in accessing appropriate professional support in his new role.	Medium	**XR- 208**	The Clinical Lead is now enrolled in the RCR Clinical Lead network.The clincal lead will be required to attend a relevant course to support their new role.			
	Managing concerns						
14	Carefully review and act on the recommendations made in the confidential appendix to this report.	High	**XR- 208**	This recommendation has been covered and is now complete.	SW/PA		
15	Review how processes for raising and responding to concerns are documented and ensure that all staff with professional leadership and management responsibilities understand how to respond to and document such cases, and how to communicate appropriately with colleagues who are directly or indirectly impacted.	High	XR-701, XR-208	Processes for raising concerens are well defined and established and in keeping with all healthcare organisations. All staff will be made aware of the reporting mechanisms again as well as the availability of the Freedom to speak up service and that HCS promotes an open culture where staff should feel able to speak up when they feel they need to. The clinical Lead and Superintendent radiographer will work to ensure the department feel fee to speak up and that reporting structures are emphasised.	SW/PA		
	Mammography						

16	There should be an urgent multidisciplinary QA visit to assess the screening programme in its' entirety. This must include programme management, routine data collection and audit.	High	The care group will liaise with NHSE for an urgent QA vsit of screening and mammography	SW/JH/SC		26/6/2024 reply from NHSE screening QA service - do not cover Channel Islands, IOM: SW to review offsite team to provide basis of QA visit and/ or rengage with NHSE
17	Symptomatic one-stop breast clinics should be instituted, where the surgeon and radiologist are co-located and work together.	Medium	As above action with RCR report	JH/SC/NW		
18	MDT function should be externally assessed.	High	Links to governance function in department. Tie to QA visit to assess and report on functionality and QA of MDT.	SW/JH/SC		
19	Equipment: a. The current digital mammogram (DM) unit is old, and the images are poor. It should be replaced as a matter of urgency. b. Any second DM unit should be co-located with clinical and ultrasound rooms to enable one-stop clinics to take place. c. Replacement and new DM units should be DBT biopsy and contrast mammography ready.	Medium	Review options and purchase feasibility. All items to be reviewed against capital programme and decision on need for draw down on 24/5 funding. Link to medical equipment committee and procurement on purchase feasibility.	JH/SC/NW		
	Serious consideration should be given to having a radiographer advanced practitioner as breast imaging lead to improve management of the unit	Medium	Consider relationship between exisiting lead and harmonising relationships with mammogrpahers. Dual role	NW/ JoanneH		

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Medicine Improvement Plan**		
Date of Meeting:	25 July 2024	**Agenda Item:**	**14**

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

Purpose of Report:	Approval ☐	Assurance √	Information √	Discussion ☐
	This paper provides information and update on the Medicine Improvement Plan.			
Summary of Key Messages:	The key messages arising from this report are: - Currently 10 out of 66 recommendations have been identified by Medicine Care Group as complete (up from 7 in May), of which 4 have been confirmed as having robust evidence/ business-as-usual process. 6 are under review to ensure robustness of evidence and sustainability of any business-as-usual processes prior to approval by Medicine Care Group Senior Leadership Team.			
Recommendations:	The Board is asked to note the content of the report and acknowledge the ongoing progress of completion.			

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

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Change Programme Board	3 July 2024	Noted
Medicine Improvement Plan Group	Weekly	Weekly Monitoring

List of Appendices:
HCS Advisory Board – Medicine Improvement Plan – Exception Report
Medicine Improvement Plan – Poster – Approved 20240701

MAIN REPORT

The Medicine Improvement Plan was established on 1st November 2023, with the aim to deliver a comprehensive improvement plan following external reviews from:

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

The recommendations have been collated and consolidated, totalling 66 recommendations to become embedded as part of the business-as-usual processes of the organisation.

During June the following progress has been made:

- Ongoing support from External Physician Advisory Support for development of Same Day Acute Care service and patient flow model.
- Ongoing review of the inclusion of Serious Incidents within the Medicine Improvement Plan. Confirmed these are to be a separate “theme” where they are not duplicates of report recommendations. Serious Incident recommendations will be monitored through the Medicine Improvement Plan, led by the Medical Services Governance Support. Review underway to confirm themes across Serious Incidents and progress to date.
- Confirmed Operational Leads for high priority recommendations with sub-tasks and due dates identified for these recommendations.
- Ongoing evidence collation of recommendation completion and/or evidence of embedment of business-as-usual process to support sustainability of the completed recommendations. This will then be presented to the Medicine Care Group Senior Leadership Team for critical review and final approval.
- Ongoing embedment of reporting and governance processes of the Medicine Improvement Plan.
- Confirmed reporting requirements of bi-monthly papers to HCS Advisory Board and to the Quality, Safety and Improvement Committee.
- The following 10 recommendations are no longer red following evidence of ongoing progression of work.
    - Rec.ID#006 – Nursing Workforce Planning
        - Ongoing development of HCS Nursing Workforce Strategy and Nurse Strategy for each service. This recommendation has been made amber.
    - Rec.ID#015 - To review the relocation of EAU to Plemont Ward (2014)
        - Confirmed this recommendation is regarding the relocation of wards in 2014 which has been completed. This recommendation has been approved as complete.
    - Rec.ID#017 – Audit Process
        - Confirmed that Medical Care Group have signed up to HQIP audit programme and there is an Audit Lead assigned to each division. Governance Lead to discuss further with Clinical Audit and Effectiveness Manager. This recommendation has been made amber.
    - Rec.ID#024 – Blister Packs

        - Confirmed blister pack service reviews were undertaken in 2018 and 2022 with the outcomes of these being reviewed. A patient risk assessment form is being piloted for 1 month, with the aim to reduce the number of requests for blister packs. This recommendation has been escalated to MIPMM.
    - Rec.ID#031 – AAU structure, function and service model
        - Confirmed reviews and models completed by the service since this recommendation was provided, ongoing development of the service strategy and model. This recommendation has been made amber.
    - Rec.ID#044 – Same Day Acute Care (SDAC) Service Model
        - External Physician is supporting the review of the suspended SDAC service and, with staff, is developing the future service model to be approved at Medical Care Group Governance Meeting in July. SDAC service to commence in July as part of the PDSA cycle, to identify and implement continuous improvements to the service, with the aim to develop a robust and definitive service model. This recommendation has been made amber.
    - Rec.ID#054 – Cardiology Inpatient Clinical Strategy
        - Noted that Cardiology has a service strategy in place. A drafted inpatient clinical strategy is to be taken for review to the Care Group Governance Meeting in July. This recommendation has been made amber.
    - Rec.ID#062 – Patient Charter
        - The HCS Patients and Users' Public Engagement Panel are developing a Patient Charter which was presented at June HCS SLT for comments. Developments of the charter are ongoing prior to submission to HCS Advisory Board. This recommendation has been made amber.
    - Rec.ID#071 – Bed Escalation Policy
        - Policy is in development, due to circulated with staff for comments in July, for submission to the August Policy & Procedure Ratification Group (PPRG) for approval. It is noted that the monitoring of non-clinical transfers is reported at the HCS Advisory Board, which has had a downward trend (positive). This recommendation has been made amber.
    - Rec.ID#073 – ERCP Referral
        - Discussions have been held with Portsmouth Clinical Director who confirmed capacity, but review needs to be undertaken of the referral pathway. Ongoing scoping of ERCP as-is pathway by Quality Improvement Lead, to lead into identification of improvements to be collated into a report for HCS SLT review. Noted that ERCP is an agenda item at the daily Ops Meeting. This recommendation has been made amber.
- Confirmed 4 recommendations complete with robust evidence, this is regarding a substantive fulfilment of the AAU Ward Manager, the historic relocation of EAU (AAU) and Executive monitoring and oversight of the implementation of the recommendations and real time whiteboard updates in AAU.
- Ongoing discussions regarding the development of a communication and engagement plan with Medical Services Care Group regarding the Medicine Improvement Plan and cultural improvement elements in the Care Group, to ensure there is continuous engagement with staff. The Medicine Improvement Plan meetings have been extended

to include Clinical Fellows, Ward Managers, and to be recruited to Clinical Director post to ensure the progress is shared across the service. It is noted to date that the Medicine Improvement Plan has been shared with staff through Consultant Meetings and Inset Days and with senior clinical leaders at the Medicine Strategy Day held in June 2024. A monthly newsletter has been established and distributed across the Care Group in staff areas and through huddles, to advise staff of ongoing progress and secure support.

Key actions for July:

- Development of the communication and engagement plan of the Medicine Improvement Plan and culture elements across the service. To consider for inclusion asking staff four key questions, Executive and Senior Leadership Ward Visits, Diagonal Slice Meetings and listening sessions.
- Ongoing progress of identified high priority recommendations.
- Ongoing review of evidence for recommendations identified as complete, prior to final approval by Medical Services Care Group Senior Leadership Team.
- Finalisation of Serious Incidents review of themes and progress to date, to enable implementation of focused response that is monitored through the Medicine Improvement Plan.
- Finalisation of the overarching Medical Care Group Strategy.
- Finalisation of plans to launch the Same Day Acute Day (SDAC) service as part of the Plan-Do-Study-Act (PDSA) cycle, to identify and implement continuous improvements to the service, with the aim to develop a robust and definitive service model.

Progress to date

Currently 10 out of 66 recommendations have been identified by Medicine Care Group as complete (up from 7 in May), of which 4 have been confirmed as having robust evidence/ business-as-usual process. 6 are under review to ensure robustness of evidence and sustainability of any business-as-usual processes prior to approval by Medicine Care Group Senior Leadership Team.

High level progress to date can be found below:

	May Advisory Board	**June** QSI Committee	**July** Advisory Board
Total Number of recommendations	**70**	**67**	**66**
Complete signed off	0	1	4
Complete	7	6	6
Green	8	14	12
Amber	44	42	41
Red	11	2	1
Escalate	0	2	2

High level information of the red recommendation can be found below, which has been discussed with an agreed mitigating action at the Medicine Improvement Group on 10th July 2024. A detailed breakdown of this, and the escalated recommendations, can be found in the attached exception report.

Rec.ID	Topic	Exception	MIPMM Outcome
058	Neurology Review	Ongoing concerns within the service.	Terms of reference for Royal College review agreed in April 2024. RAG rating to be reviewed once review date is confirmed.

Finance / Workforce Implications

The following recommendations have identified finance and workforce implications:

- Rec.ID#004 - Full acute medicine consultant recruitment
  - Ongoing recruitment to the "Future Vision" medical model which aspires to ensure resilience and evidence-based medicine of high calibre Consultant Grade posts to support the ambition to provide high quality care.
  - Ongoing recruitment to 5 Consultant Grade posts.
  - Further 6 posts require approval of funding to enable a resilient workforce model, paper submitted to HCS SLT in July 2024, which confirmed further financial review required.
  - A business case is to be established following this to support the implementation of the model.
- Rec.ID#031 - AAU structure, function and service model
  - Confirmed not to recruit to 1 Flow Co-Ordinator post due to funding allocation of budget from within the Medical Care Group financial envelope.
- Rec.ID#026 - Nursing Workforce Planning
  - Following approval of ECA Standard Operating Procedure, a training needs analysis is to be conducted for Doctors and Nurses to ensure correct workforce skill set and model are adequately supported, which may have financial implications.

Risk and Issues

The competing goals of delivering operational performance and evidencing against recommendations place a great deal of pressure on clinical department lead staff and Medicine Care Group Senior Leadership Team. To mitigate this, additional resource has been sourced to include an External Physician Advisory Support, Governance Support, and interim General Manager support. Extra capacity has been sourced within the Care Group including extending Medicine Improvement Plan meetings to Clinical Fellow, Ward Managers, and to be recruited to Clinical Director. A monthly newsletter has commenced, which hopes to identify further resource within the Care Group to support the plan.

There is a further issue for support regarding allocated Project Manager resource, who is unable to progress the Medicine Improvement Plan at the required pace, due to capacity working on Maternity Improvement Plan, resulting in delayed monitoring/tracking of recommendations. This is being mitigated through identification of Maternity Improvement Plan Phase 2 Lead, to commence phased handover from June - September 2024.

Recruitment to vacancies remains a priority. Actions to shorten the time to recruit to allow for sustained pace to quality improvements also sit within the Financial Recovery Plan (FRP) due to risk of agency premium. It is hoped that the ongoing HR re-design will provide the service with more HR capacity, to support timely recruitment processes and establishment of a recruitment package.

Recommendation

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

END OF REPORT

Health and Community Services

Medicine Improvement Plan Exception Report

25 July 2024

Government of Jersey

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.

Introduction

The Medicine Improvement Plan was established on 1st November 2023, with the aim to deliver a comprehensive improvement plan following external reviews from:

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

The recommendations have been collated and consolidated, totalling 67 recommendations to become embedded as part of the business-as-usual processes of the organisation.

Governance Arrangements

- Medicine Care Group SLT and MIP Working Groups
    - Weekly review of excel medicine improvement plan
    - Purpose is to review progress of actions and their tasks, support requirements and identify risks and issues
- Medicine Improvement Plan Monitoring Meeting – led by the Chief Operating Officer – Acute Services
    - Weekly presentation progress report and theme summary
    - Purpose is to review reds, 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 Quality, Safety & Improvement Committee
    - Bi-monthly cover page and report
    - Purpose is to provide assurance of progress against the MIP and embedding and sustainability of outcomes.
- HCS Advisory Board
    - Bi-monthly cover page and report
    - Purpose is to provide assurance of progress against the MIP and embedding and sustainability of outcomes.

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 Medicine Improvement Plan Monitoring Meeting. 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.

High level progress to date

Total Number of recommendations	**May** Advisory Board	**June** QSI Committee	**July** Advisory Board
	70	**67**	**66**
Complete signed off	0	1	4
Complete	7	6	6
Green	8	14	12
Amber	44	42	41
Red	11	2	1
Escalate	0	2	2
Not started	0	0	0

Not Started – Work to deliver against recommendation has not started

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

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 Medicine Care Group Senior Leadership Team

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

Escalated recommendations to Medicine Improvement Plan Monitoring Meeting

Rec. ID#	004	Report	Royal College of Physicians Invited Service Review 18 – 20 June 2014 Dr Rob Haigh Review 21 - 24 August 2023
Consolidated Recommendation Description	Full acute medicine consultant recruitment. See detailed recommendation for specialty areas and themes to address.		
Progress to date and cause of the exception and impacts	11 Consultant posts have been identified to be recruited to, with an associated structure developed and approval in principle at HCS SLT November 2023. 5 Consultant posts have funding, and recruitment is progressing: • 2 posts have been offered (Stroke, Acute Medicine) with contracts waiting to be provided. • 3 posts require approval of job descriptions (Renal x1, Respiratory x2) from HCS HR and Royal Colleges prior to advertisement. 6 Consultant posts require approval of funding prior to recruitment. It is noted that the delay for approval of funding is due to financial pressures across HCS. The issues and risks associated with this recommendation, such as lengthy recruitment timeline and lack of funding, have been escalated to the Medicine Improvement Plan Monitoring Meeting weekly. This recommendation has been escalated due to the lengthy recruitment time and requirement of Executive approval of funding for 6 remaining posts.		
Raised at MIPMM	15/05/2024, 22/05/2024, 29/05/2024, 05/06/2024, 12/06/2024, 19/06/2024, 03/07/2024, 10/07/2024		
MIPMM Outcome	This recommendation was escalated to MIPMM 10/07/24 where it was agreed to continue escalation to MIPMM until financial position changes.		

Rec. ID#	024	Report	Royal College of Physicians Invited Service Review 18 – 20 June 2014
Consolidated Recommendation Description	Pharmacy must be in a position to dispense blister packs.		
Progress to date and cause of the exception and impacts	It is noted that the current blister pack process is not efficient, and that only two community pharmacies produce blister packs, with a production time of 7-10 days, which results in delayed discharge for those patients. Hospital Pharmacy are unable to dispense blister packs due to space and resource capacity. It is noted that UK Government bodies advise against the use of blister packs. Blister pack service reviews were undertaken in 2018 and 2022 which identified that low demand, equipment and resource costs resulted in the decision to not progress in house, and instead commission to a community pharmacy. This progression of this was stopped. It has been identified that a patient risk assessment form should be completed prior to the dispensing of blister packs, in line with NICE guidance. This is being reviewed at the Medical Compliance Meeting and it is hoped that the implementation of this patient risk assessment form, may reduce the number of patients requiring a blister pack and therefore reduce delayed discharge for those patients. This is being piloted for 1 month in AAU, Plemont Ward and Corbiere Ward, with results expected in July.		

	Ongoing review to determine the inclusion of blister packs within the Medicines Optimisation Group, to reduce duplication of work. This recommendation has been escalated as blister packs are a concern across HCS and Executive steer is required for the implementation of blister packs.
Raised at MIPMM	15/05/2024, 22/05/2024, 29/05/2024, 05/06/2024, 12/06/2024, 19/06/2024, 03/07/2024, 10/07/2024
MIPMM Outcome	This recommendation was escalated to MIPMM 10/07/24 where it was agreed to continue the 1 month pilot and commence discussions of pathways and processes with community pharmacies.

Red recommendations

Rec. ID#	058	Report	Serious Incident
Consolidated Recommendation Description	Review Neurology and Neurosciences with the aim of improving the provision of medical expertise in this specialty, in particular the inpatient provision.		
Progress to date and cause of the exception and impacts	Terms of reference for the review have been agreed with the Royal College of Physicians on 10th April 2024 and have been logged as evidence. Medical Services are waiting for Royal College of Physicians to confirm the review date, which is expected to be in Q3-Q4 2024. Ongoing collation of medical notes to be sent to the Royal College prior to their review. The upcoming review has been discussed with the Neurology service on 3rd June 2024. Following publication of report, to review the recommendations and develop an action plan for improvements. This recommendation has been confirmed to remain red due to ongoing issues and concerns within the service.		
Raised at MIPMM	15/05/2024, 22/05/2024, 29/05/2024, 05/06/2024, 12/06/2024, 19/06/2024, 03/07/2024, 10/07/2024		
MIPMM Outcome	It was agreed at MIPMM 10/07/24 for this recommendation to remain red and RAG rating to be reviewed once report date is confirmed.		

Medicine Improvement Plan

The Medicine Improvement Programme (MIP) was established in November 2023. The purpose is to deliver coordinated and sustained improvements within Medicine to address the recommendations from the internal reports which have received by the organisation, to ensure that responses become part of the embedded business-as-usual governance process of the organisation.

June 2024 progress

Reporting
Embedment of reporting and governance processes of the Medicine Improvement Plan with 2 out of 67 recommendations complete

Blister Packs Assessment Form
1 month pilot started in AAU, Plemont and Corbiere Ward to review appropriate prescribing of blister packs

Red, Amber, Green
9 red recs made amber, such as SDAC Strategy, Cardiology Inpatient Clinical Strategy and Patient Charter

Serious Incidents
Review of SIs to ensure a focused, thematic response that are monitored through the MIP

SDAC Strategy
Development of the Same Day Acute Care service model

July

Serious Incidents
Finalisation of SI review to confirm monitoring and reporting of these within the Medicine Improvement Plan

Strategy
Medical Care Group Strategy to be finalised

Same Day Acute Care
Launch of the SDAC service in July as part of a PDSA cycle

ERCP Pathway
Ongoing review of the ERCP pathway to identify improvements to be made

Your voice

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

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**2024 HCS Annual Plan - Q2 Progress Report**		
Date of Meeting:	25th July 2024	**Agenda Item:**	**15**

Executive Lead:	Dr Anuschka Muller, Director of Improvement and Innovation
Report Author:	Harry Hambrook, Senior Business Planner

Purpose of Report:	Approval √	Assurance ☐	Information √	Discussion ☐
	For the Board to review and approve: - a consolidated Q1 and Q2 update on the deliverables within HCS' 2024 Annual Plan, and - amendments to some of the 2024 Annual Plan's deliverables.			
Summary of Key Messages:	The appended '*2024 HCS Annual Plan - Q2 Report'* report shows the progress made from January to June 2024 against the objectives set out in HCS' 2024 Annual Plan. Please note that the narratives for four Service Performance Measures are outstanding and will be updated in due course. Amendments have been made to some of the deliverables in the '2024 Annual Plan' by the owners of the relevant sections, which can be viewed in the version control section at the front of appended '*HCS Annual Plan 2024 V0.6*'.			
Recommendations:	The Board is asked to note and approve the Q2 report and the amendments to the deliverables in the Annual Plan.			

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

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
HCS Senior Leadership Team	11th July 2024	Approved

List of Appendices:
Appendix 1: 2024 HCS Annual Plan - Q2 Report
Appendix 2: HCS Annual Plan 2024 V0.6

Health and Community Services

Gouvèrnément d'JÈRRI

2024 Annual Plan Report for Q2

Contents

Introduction

The HCS Annual Plan 2024 gives an overview of the department's plans for areas of improvement, strategic initiatives and quality and performance reporting for the year. We have a significant and varied programme of work for 2024 including the New Healthcare Facilities Programme (NHF), preparing for inspection by the Jersey Care Commission (JCC) and commissioning effective, safe, and high-quality services for Islanders.

In this report, we provide information on our 2024 Q1 and Q2 progress on the achievement of our plans. When reporting on the progress of our plans, we have used the key below.

Status		
Not Yet Started/ On Hold		Activity not yet started or is on hold
On Track		Activity proceeding as planned
Potential for delay		A possible but not yet actual delay in the delivery of the activity
Delayed		Activity has slippage and will not meet the expected delivery date
Complete		Activity complete

Commissioning

Commissioning in Jersey is defined as 'the process of continuously developing services and committing resources to achieve the best health outcomes for individuals and the population, ensure equity and enhance experience within the resources available'. Working in partnership with other Government Departments, Commissioning has made progress on the delivery of the high-level tasks shown in the table below.

Action	Measure	Due Date	Status	Supporting Narrative
Use the Mental Health Provider Framework to procure services in a fair and transparent way. Run a mini competition for low level anxiety and depression services.	Contract award following mini competition	Q2 2024		**Complete**. Following the launch of a mini-competition, bids were evaluated at the end of May. After the evaluation report was signed-off, all bidders were notified of the outcome and the contract awarded. Further mini competitions are planned later in the year.
Develop and deliver a neurodiversity strategy for Jersey, working in partnership with Autism Jersey and key stakeholders.	Ratification of strategy	Q3 2024		**On Track**. In conjunction with Autism Jersey, good progress has been made on the development of a strategy. A project plan has been drafted and the steering group has met and constructed a communication plan. Working closely with HCS communications, informatics, the design team, and the neurodiversity networks, an island-wide all age survey has been developed. Results will inform the strategy. Service mapping has begun, and a stakeholder champions meeting has been set up to sense check the work. Their channels and influencers will be used to promote the strategy and gain feedback from harder to reach groups. Meetings with the cluster groups in July and parish roadshows will take place through the summer months.

Action	Measure	Due Date	Status	Supporting Narrative
Recommission community services to up-to-date specifications based on assessment of need, testing value for money.	Contract award following commercial process	Q3 2024		**On Track**. The Procurement Strategy and supporting documents have been completed. Key Performance Indicators (KPIs) are finalised and the 'Route to Market' has been confirmed. Following negotiation meetings in the summer, next steps in the recommissioning process will be confirmed.
Continue implementation of the Palliative and End of Life Care Strategy through commissioning education and end of life care at home services.	Education and end of life care at home service commencement	Q4 2024		**On Track**. Meetings to plan education and end-of-life care at home services took place and involved a range of stakeholders. Initial proposals were agreed at the End-of-Life Partnership Group in April and have been further developed into detailed plans. The plans were presented to the End-of-Life Partnership Group in June. The plans were approved in principle, with a recommendation for further work on the end-of-life care at home service operational elements to be done before sign-off for implementation by HCS.

Improvement Recommendations

From C&AG, PAC, and Scrutiny Panels

HCS receives recommendations from various bodies and individuals, following reviews and audits conducted on the department. Progress on the implementation of recommendations is being monitored on a quarterly basis, with evidence of progress and completion being provided to HCS' Senior Leadership Team for assurance of progress.

Considerable progress has been made this quarter, which is evidenced from the ***completion of 14 recommendations***. Whilst not yet officially closed, significant work has been underway on implementing recommendations from historic Mental Health and Maternity reviews, which are expected to be closed in Q3.

The table below shows the number of HCS' open recommendations from the Comptroller & Auditor General (C&AG), the Public Accounts Committee (PAC), and Scrutiny Panels by quarter.

Date Published	Title of Report	Number of Recommendations open					
		Start of Year	Q1	Q2[1]	Q3	Q4	End of Year
Comptroller & Auditor General (C&AG) Reviews							
12 Oct 2015	Review of Community and Social Services	1	1	-			
20 Oct 2021	Governance Arrangements for Health and Social Care (Follow Up)	1	1	-			
22 Sep 2022	Child and Adolescent Mental Health Services	3	2	1			
24 Jan 2023	Deployment of Staff Resources in Health and Community Services	12	12	10			
15 May 2023	Learning from Previous Hospital Projects: A Follow Up Review 2023	6	6	1			
20 Nov 2023	Handling and Learning from Complaints	2	2	1			
Public Accounts Committee (PAC) Reviews and Reports							
12 Apr 2022	Response to the COVID-19 Pandemic by the Government of Jersey	1	1	1			

[1] Please note that the figures for the C&AG and PAC recommendations are subject to confirmation by the Risk and Audit Committee (RAC) in July 2024.

Date Published	Title of Report	Number of Recommendations open					
		Start of Year	Q1	Q2[1]	Q3	Q4	End of Year
Health and Social Services Scrutiny Panel Reviews							
06 Mar 2019	Assessment of Mental Health Services	9	9	9			
17 Nov 2020	Review of the Government Plan: 2021 – 2024	1	1	1			
22 Sep 2021	Review of Maternity Services	23	23	23			
01 Oct 2021	Our Hospital Outline Business Case and Funding Review	2	2	2			
11 Feb 2022	Government Plan 2022 – 2025 Scrutiny Review	4	4	1			
31/08/2022	Follow-Up Review of Mental Health Services	20	20	20			
Authored by the Economic and International Affairs Scrutiny Panel							
26/04/2022	Regulations for the Licensing, Production and Export of Medicinal Cannabis in Jersey	1	1	1			
TOTAL Number of Open Recommendations		**86**	**85**	**71**			

Jersey Care Commission Preparation

The Jersey Care Commission (JCC) regulates and inspects services for both adults and children provided by the Government of Jersey, Parishes, private providers, and the voluntary sector. The services currently regulated include care homes providing nursing and personal care, domiciliary care, adult day care, and children's services. The JCC are currently working with the Care Quality Commission (CQC) and have drafted the JCC's Care Standards - Single Assessment Framework (SAF) for hospital services, which were open for consultation until the end of May 2024. A further proposed amendment to the Regulation of Care (Jersey) Law 2014 has now been closed for consultation. Once the amendments to the Law have been finalised, HCS will be required to register our services and will then be subject to inspection in 2025.

Whilst the JCC's Care Standards - Single Assessment Framework is being ratified, HCS will focus on ensuring that we can evidence the JCC's five Key Elements of Care (KEC) and what these mean for service users.

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

Action	Measure	Due Date	Status	Supporting Narrative
Establish a Steering Group of key senior staff to develop a programme or work, including mock inspections and benchmarking against CQC standards.	Steering Group established	Q1 2024		**Complete**. A compliance team has started within the Quality and Safety Team, who have established a Regulatory Oversight Steering Group to which all additional parties are invited. The Terms of Reference (ToR) have been drafted and a final version has been circulated. A Peer-to-Peer review process is being run by the Chief Nurse's office, which works closely with the Compliance and Assurance team (C&A). The peer review process allows clinical and non-clinical perspectives, including staff and patient feedback and governance processes.

Action	Measure	Due Date	Status	Supporting Narrative
Picker Institute to conduct a patient experience survey and publish results which will inform our understanding of patient experience and any changes since the 2022 survey.	Results published	Q1 2024		**Complete**. The Picker Institute's Patient Experience survey is complete and has been published. The Compliance and Assurance team will use it as evidence to reflect against the standards of the JCC's Single Assessment Framework.
Secure capacity to support clinicians in preparing for JCC inspections and to lead on preparation and response to JCC inspections.	Capacity established	Q2 2024		**Complete**. All Care Groups and key staff have been consulted on the consultation of the JCC Single Assessment Framework. The Compliance and Assurance team are meeting with each Care Group to ensure relevant support is provided.
Timely registration of HCS services once JCC opens the registration process.	Registration completed	Q1 2025		**Not Started.** HCS will register when the Regulation of Care (Jersey) Law 2014 has been approved, which is expected to be in January 2025.

The New Healthcare Facilities Programme

We know that our current facilities (buildings) are deteriorating, this represents a considerable risk to our capacity to deliver acute health and care services. We need environments to be fit for purpose and to meet modern healthcare standards. As well as the continual maintenance of our current facilities, several capital construction projects will be delivered. Key elements of the planned work include delivery of a new acute facility at Overdale and a health village at St Saviours which integrates elements of physical health with mental health services. There is also the development of Ambulatory Care facilities on Kensington Place, whilst utilising some of the existing on the General Hospital site.

Action	Due Date	Status	Supporting Narrative
Transfer of the current Rehabilitation Ward into new, temporary facilities, where they will stay until the development of the Health Village is completed.	Q1 2024		**Complete**. The lease for St Ewold's has been signed and all patients and staff have been transferred. Although not delivered by Q1, the project is now fully complete and delivered for Q2.
Completion of Outline Business Case for an acute site at Overdale.	Q2 2024		**Complete**. The draft Outline Business Case has been completed. It will undergo review and approval through the relevant governance channels.
Submission of the Planning application for the revised plans to develop the Acute Hospital on the Overdale site.	Q3 2024		**On Track**. The planning application for the Acute Hospital development are complex and require a large number of inputs. However, work is on track with submission expected in September 2024.
The demolition of buildings on the Overdale site, in preparation for the acute hospital build.	Q3 2024		**On Track**. The demolition at Overdale is proceeding well, with the likely completion of all works by August 2024.
Improvements on the Kensington Place site, with some possible temporary use of the site for HCS requirements.	Q3 / Q4 2024		**On Track**. A number of temporary uses have been suggested for the site. Advisors will be engaged to enable the formulation of initial decisions. Progress on this work has been delayed due to the impact of the requirements of the Programme's Acute Phase. Meaningful progress will be made in Q3 and Q4, keeping the end date on track.
States Assembly funding debate: to secure finances to support the delivery of the first phases of the Programme.	Q4 2024		**On Track**. Funding requirements for the New Healthcare Facilities Programme will be presented to the States Assembly as part of the Government Plan. This is due to be lodged in July 2024, and debated by the States Assembly in Q4.

Digital Health Programme

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

On Friday 23rd February, the Hospital's IT system suffered a critical incident. The Government's IT department are carrying out an investigation into the cause of the incident and how to prevent it happening again. As a result, several projects within the Digital Health Programme were delayed whilst resources are focused on the investigation.

Project	Detail	Due Date	Status	Supporting Narrative
Vendor Neutral Archive (VNA)	Implementation of a strategic method for clinical image storage, which improves efficiency and scalability.	Q1 2024		**Complete**. Vendor Neutral Archive has been implemented, integrated into business as usual and the project formally closed.
Obstetric Sonography System Software	Replace / upgrade the current ultrasound / scanning report application.	Q2 2024		**Complete**. Obstetric Sonography System is now live, and preparations are being made for formal Project Closure.
Primary Care System review	Review the current Primary Care system solution and establish requirements for re-tender.	On Hold		**On Hold.** The project is on-hold as the current contract is being extended to allow for the capture of detailed requirements and the commercial procurement process to take place.
General Practitioner (GP) Order Comms	To replace the paper-led requesting and reporting process which will reduce result turnaround times, provide a fully audited service.	Q3 2024		**On Track**. The rollout has expanded to all but one GP practice and over 70% of GPs are using the system. Internal and external communications are in progress to gain full engagement.
Jersey Health & Care Index (HCI)	An essential project to ensure consistency of patient data.	Q3 2024		**On Track.** This project has been extended due to the GoJ technical issues and change freeze in May/June. Good progress is now being made, although the target for go live has been pushed back to Q3 2024.

Project	Detail	Due Date	Status	Supporting Narrative
Faecal Immunochemical Testing (FIT)	To digitally support the FIT booking and screening process which will increase the number of patients who can be screened - improving detection and treatment.	Q3 2024		**On Track**. The GoJ change freeze in May/June delayed this project and so the completion date is now Q3 2024.
Picture Archiving & Communications Systems (PACS)	Replacement of a legacy system, with migration of images and image reporting history. Will also provide clinical image reporting services.	Q3 2024		**On Track.** The new Picture Archiving & Communications Systems is now live. Decommissioning of the old system is in progress alongside closing-down the project, with an anticipated end date of July 2024.
Audiology: Audit Data replacement for Practice Navigator	Replace legacy system.	Q3 2024		**On Track.** The system is now live and on track to be completed in July 2024.
Ophthalmology Electronic Patient Record (EPR)	Implementation of a new EPR system to create automation and efficiencies, to deliver shorter waiting times.	On Hold		**On hold**. Due to resource constraints. Review planned for 2025.
IT Service Model review for commissioned services	Ensuring compliance with IT infrastructure standards and contractual arrangements.	Q4 2024		**On Track**. The project went live in June 2024. Governance has been progressed quickly from Stage 0 (Pipeline) to Stage 3 (Delivery). The project is currently on target for the existing Go Live dates, however due to a large series of interconnected dependencies, there is a risk that if delays from outbound dependencies occur; this could impact our timeline & RAG status. Therefore, a prospective Plan B and a subsequent Plan C has been agreed with Project Board (For all the plans, the target project closure date is during October 24).
Electronic Patient Medicines Administration (EPMA)	Deployment of infrastructure, to improve clinical compliance and safety.	Q4 2024		**Slippage**. EPMA roll out is complete but the upgrade to 8.2 is delayed because of some software functionality issues. Discussions are ongoing with the supplier to assess potential solutions.

Project	Detail	Due Date	Status	Supporting Narrative
Sexual Health Clinic Electronic Patient Record (EPR)	To capture structured clinical data and remove the current paper-based process.	Q4 2024		**On Track.** There has been significant progress to clarify the project deliverables (product quality) and distribution of tasks and responsibilities with our supplier. The build of design and solution with the clinical team and supplier is moving forward. Agreement has been reached regarding scope of work and completion by year end.
Hospital Electronic Patient Record (EPR)	Replacement or update of current General Hospital EPR system	Q4 2024		**Delayed.** Some of the EPR workstreams are delayed due to dependencies on the hospital Wi-Fi improvement plan. Once the patchy Wi-Fi issues in the hospital have been addressed, the Wi-Fi modules can be progressed. Workstreams are now scheduled to be implemented by mid-2025.
Cervical Cancer Screening	An essential upgrade to support the service in achieving screening targets, through increased efficiency and automation.	Q4 2024		**On Track**. The procurement strategy has been approved.
e-Consent for surgical procedures	A system that enables patients to provide their consent online.	Q4 2024		**On Track**. This is underway with detailed planning and design in progress.
Virtual Consultations	Enable virtual consultations to improve waiting times by providing Consultant led services remotely.	Q4 2024		**On Track**. This project is underway, with detailed planning.
Essential Hospital Wi-Fi	To improve connectivity in the hospital.	Q4 2024		**On Track**. The Project is underway with detailed planning and design in progress. An implementation plan is being drawn up to set out expectations on delivery and ensuring it aligns with the roll out of Electronic Patient Records.
Electronic Record System for Adult Social Care	Transformation of the system and processes to meet the service's needs.	Q1 2025		**Slippage.** The forecast for delivery has been delayed into late 2025 early 2026. Discovery work is complete. Awaiting further funding to be agreed before commitment can be assured.

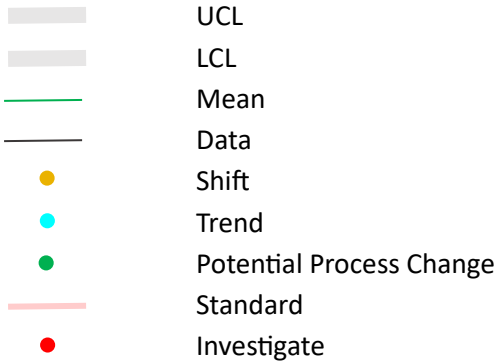
Project	Detail	Due Date	Status	Supporting Narrative
e-Referral Process	Implement a solution to replace the predominantly email led referral process.	Q2 2025		**On Track.** Conversations have been had with suppliers to define a technical solution. Detailed planning and design are now in progress, with delivery expected mid-year 2025.
e-Prescribing Chemotherapy	To reduce clinical risk and comply with best practice.	Q2 2025		**On Track**. Initial planning, funding, scoping, and initiation are in progress.

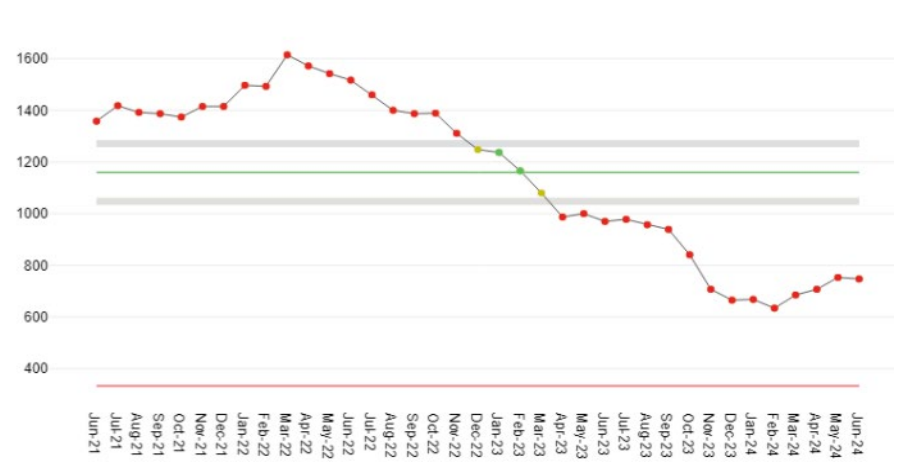
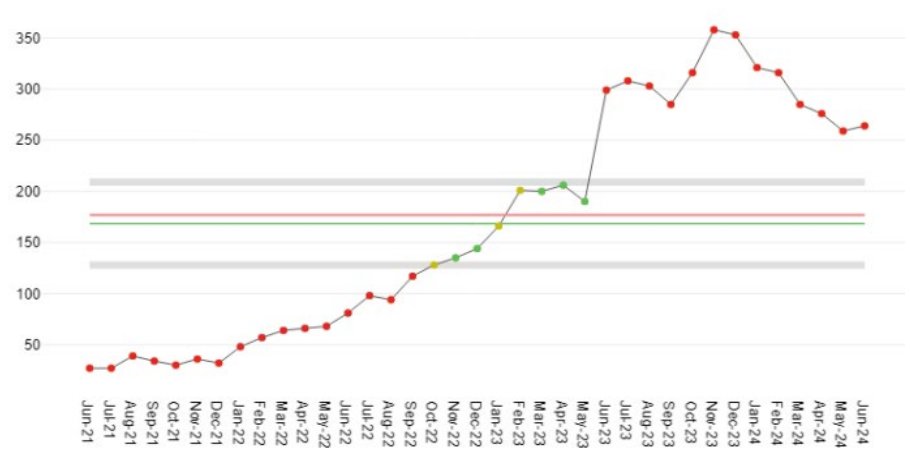
Quality and Performance Metrics

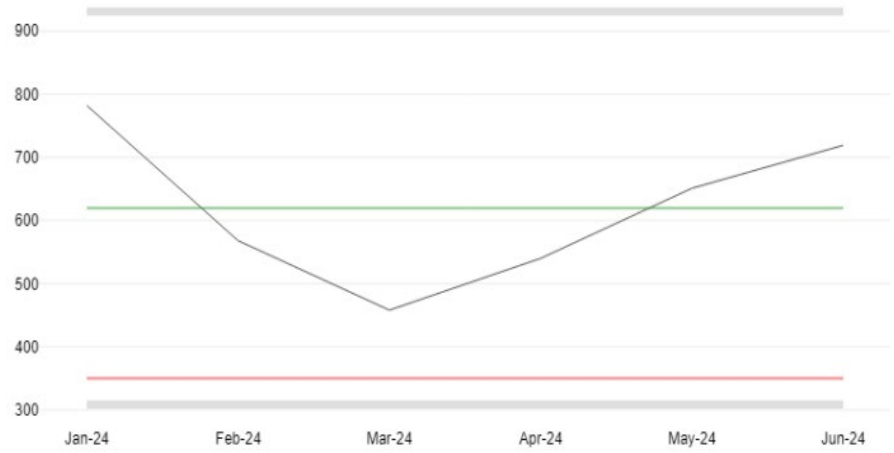
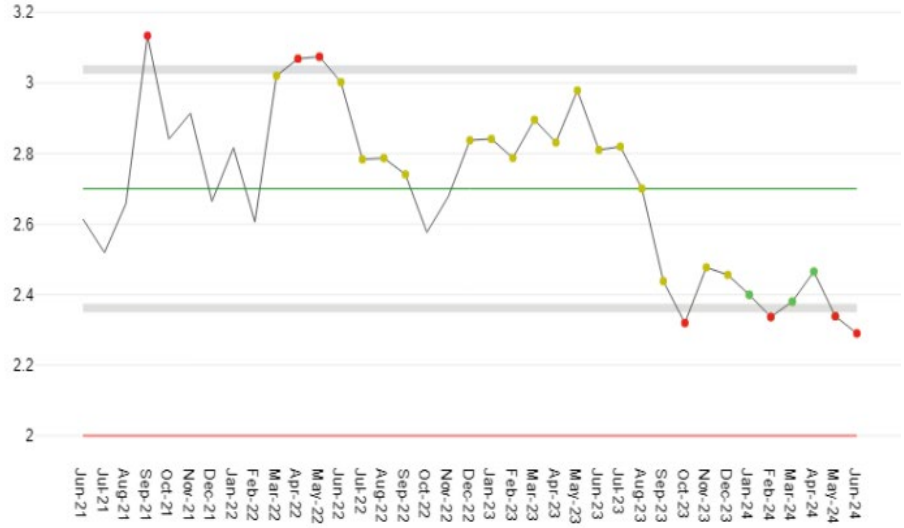
The ***Quality and Performance Report*** (QPR) provides the performance metrics and monthly performance for clinical services. The QPR is discussed monthly at the HCS Advisory Board and published in addition on Health and Community Services Quality and Performance Reports (gov.je). Further information about the Board can be found here Health and Community Services Advisory Board (gov.je).

Service Performance Measures (SPMs) are a sub-set of the Quality and Performance Report indicators and are published quarterly alongside other government departments' SPMs. They aim to provide a broad overview of the delivery of key services by all government departments. A summary of HCS's Service Performance Measures status at end of June 2024 are on the following pages.

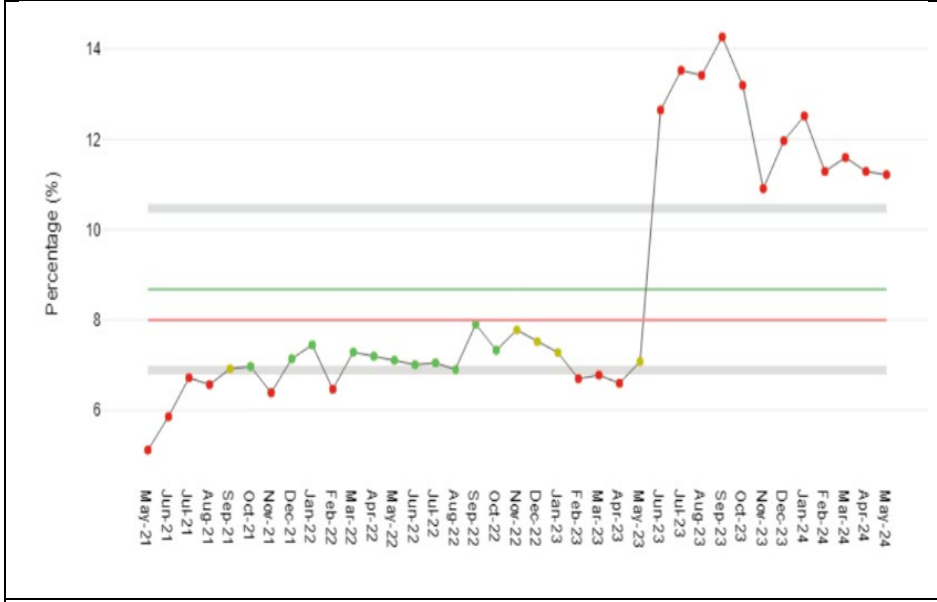
Key to Graphs



Elective Pathways: Patients waiting for first outpatient appointment greater than 52 weeks.		Elective Pathways: Patients on elective list greater than 52 weeks.	
Latest Value	Standard	Latest Value	Standard
747	<333	264	<177
			
Narrative Patients waiting over 52 weeks for their first appointment continues to fall. All long wait patient referrals have been reviewed and we continue to allocate appointments based on clinical urgency as defined by the triaging consultant. The specialties where outpatient capacity does not meet the demands of referrals, and thus longer waits are experienced by the patients continue to be dermatology, ophthalmology, gastroenterology and ENT. However, all urgent referrals are being seen within an appropriate timescale.		**Narrative** Patients waiting over 52 weeks for their elective procedure have fallen again from the last reporting period (M4). At the end of M4, the number of patients waiting over 52 weeks was 276, at the end of M6, the number of patients is 264. Orthopaedics and General Surgery continue to have the longest waits for our patients.	

Elective Pathways: Access to diagnostics greater than 6 weeks		Efficiency: Outpatient New to Follow Up (NFU) ratio	
Latest Value	Standard	Latest Value	Standard
719	<350	2.29	2
			
Narrative Diagnostic waits continue to rise within endoscopy and MRI. As described previously, the successful pilot of the MRI increased capacity has now been adopted with recruitment to the newly funded posts continuing. Once this additional substantive capacity is in place, the waiting times for MRI will reduce. Within endoscopy, the waiting list initiative earlier in the year proved successful, however capacity has since reduced whilst we wait for the new substantive consultant to commence in post at the end of July. The planned WLI for endoscopy was unable to be progressed due to lack of clinical resource to undertake the procedures.		**Narrative** New to follow-up ratio remains at an acceptable rate across most specialties and continues to be monitored.	

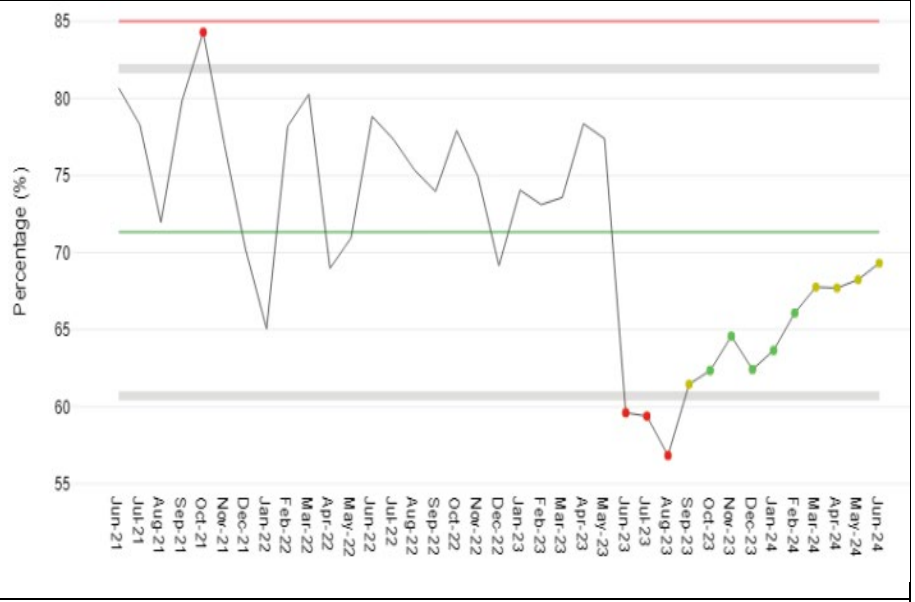
Efficiency: Outpatient DNA rate (Adults only)	
Latest Value	Standard
11.5%	<=8%



Narrative

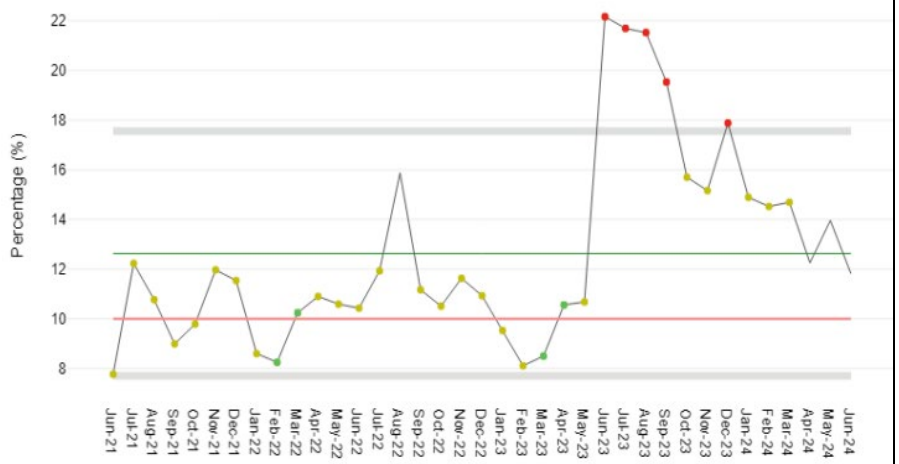
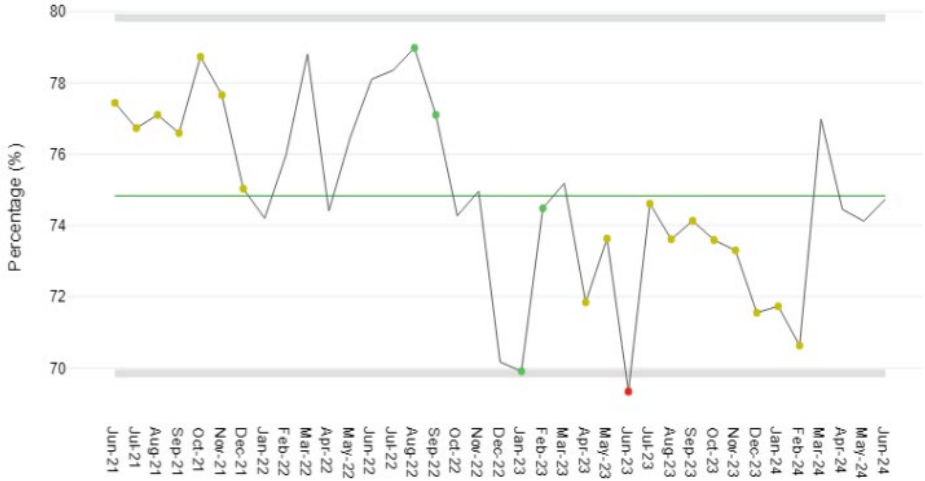
The DNA rate remains static at around 11% for the first half of the year. Ongoing work across outpatient improvement will ultimately support reductions in DNA rate, this includes process redesign and digital initiatives which have a longer-term implementation timescale.

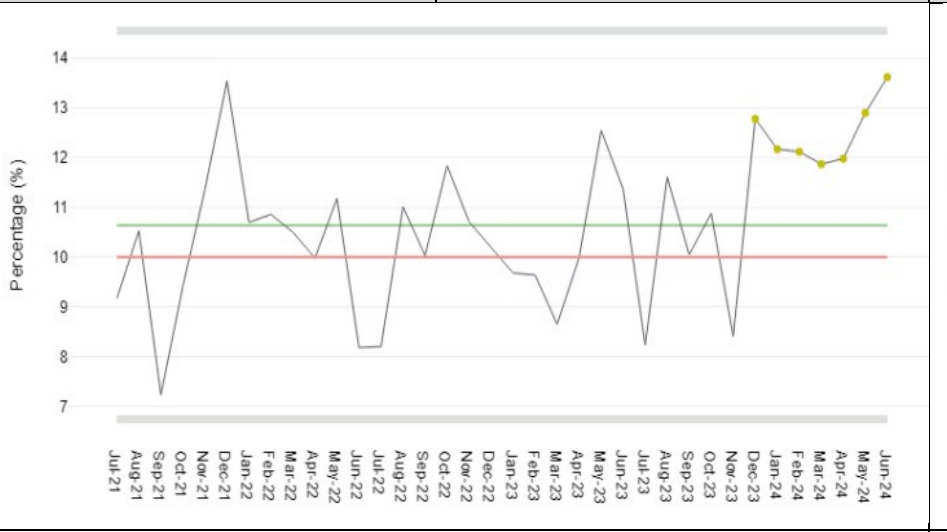
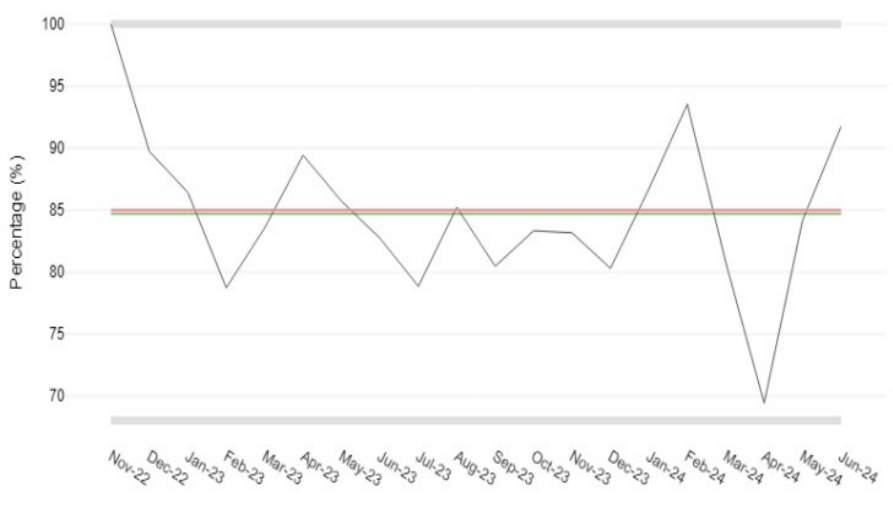
Efficiency: Elective Theatre List Utilisation (Main Theatres & Day Surgery, excluding Minor Operations)	
Latest Value	Standard
69.3%	>85%



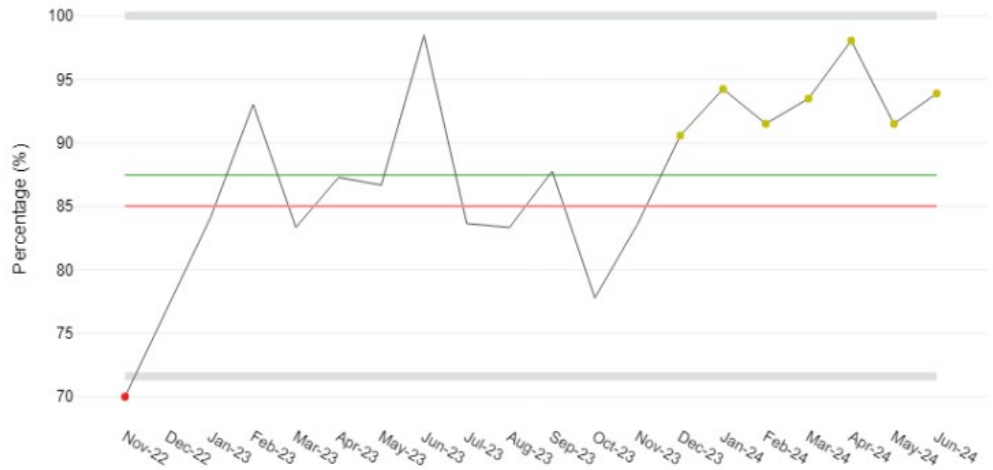
Narrative

Theatre utilisation has improved for the 7th month in a row, however, remains below the acceptable standard. Ongoing theatre improvement work, process redesign, education and training continue to have positive impact. Further intensive work across Q3 will provide further improvements in utilisation.

Efficiency: Was Not Brought Rate		Emergency Care Pathway: % patients in emergency department for less than or equal to 4 hours	
Latest Value	Standard	Latest Value	Standard
11.8%	<=10%	74.7%	74.8%
			
Narrative This rate is consistent with the DNA rate and forms part of the outpatient improvement work.		**Narrative** TBC	

Emergency Inpatients: Rate of Emergency readmission within 30 days of a previous inpatient discharge		Community Mental Health Services: % of referrals to Mental Health Assessment Team assessed in period within 10 working days	
Latest Value	Standard	Latest Value	Standard
13.6%	10.6%	91.7%	84.7%
			
Narrative TBC		**Narrative** TBC	

Community Mental Health Services: % of referrals to Mental Health Crisis Team assessed in period within 4 hours	
Latest Value	Standard
93.9%	87.5%



Narrative

TBC

Financial Recovery Plan (FRP)

Health and Community Services Advisory Board (gov.je)

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

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

A Project Management Office (PMO) was established to support delivery of the FRP and the department's Value for Money (VFM) target; by working alongside the Care Groups and Directorates. To address the challenge, efficiency schemes were developed sitting within seven workstreams. The position at Q2 2024 can be summarised.

FRP Delivery and Development Tracker – FY24 Savings Delivery[2]

Workstreams	Projects	2023 Saving Delivered	Full Year 2024 Planned Saving	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Total 2024 Savings to Date	Current RAG Status
Schemes currently in delivery									
Clinical Productivity	Theatres Efficiency	-	2,336					-	
Workforce	Clinical – Medical	221	1,723	238	251			489	
	Clinical – AHPs	119	1,489	40	208			248	
	Clinical – Nursing	-	2,230					-	
	Pay Controls (WCP)	-	450		99			99	
Non-Pay and Procurement	Non-Pay Controls (NPCP)	-	1,099	112	75			187	

[2] HCS Advisory Board - Papers - Part A - May 2024.pdf (gov.je)

Workstreams	Projects	2023 Saving Delivered	Full Year 2024 Planned Saving	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Total 2024 Savings to Date	Current RAG Status
	Procurement	585	195	195				195	
	Medicines Management	98	605	72	136			208	
	Other Non-Pay	-	224	27	32			59	
Income	Other Income Opportunities	163	781	201	89			290	
	Private Patients	242	371	89	90			179	
Care Groups & Non-Clinical Directorate Schemes	£3m in 3 months	1,914	-					-	
Schemes being prepared for delivery									
Clinical Productivity	Patient Flow and Discharge / LOS			-				-	
	Theatres Efficiency			-				-	
Workforce	Clinical - Nursing			-				-	
	Clinical – Medical		72	-				-	
	Workforce Savings		583	-				-	
Non-Pay and Procurement	Procurement		444	-				-	
	Medicines Management			-				-	
	Other Non-Pay			-				-	
	Non-Pay Controls (NPCP)		8	-				-	
Income	Other Income Opportunities		66	-				-	
	Private Patients		432	-				-	
Mitigating Schemes	Unidentified recurrent effect of 2023 £3m in 3m		489	-				-	
TOTAL FRP SAVINGS TO DATE		3,341	13,976	900				900	

Quality Account

Quality in healthcare is made up of the four core dimensions of patient experience, patient safety, clinical effectiveness, and staff wellbeing. The Quality Account is an annual report published by HCS to inform the public of how we monitor the quality of services we provide. It demonstrates our commitment to provide Islanders with the best quality healthcare services. It also encourages transparency about our service quality and helps us to develop ways to continually improve and looks forward and defines the priorities for quality improvement for the year ahead and how we expect to achieve and monitor them.

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

Priorities and Objectives	Status	Supporting Narrative
Priority 1: Develop a Learning from Deaths (LfDs) Framework for HCS		
Publication of a Learning from Deaths framework for HCS.		**Delayed.** The Learning from Death Framework has been drafted and is out for consultation pending ratification.
Implementation of Mortality Learning Review (MLR) Programme.		**Delayed.** The MLR guideline has been written and is out to consultation, this will go to the Policy and Procedure Ratifying Group (PPRG) in July.
Re-introduce Mortality and Morbidity (M&M) meetings.		**On Track**. The first meeting has taken place, further work is required in order to ensure that actions are logged and monitored.
Commence a Learning Disability Mortality Review Programme (LeDeR).		**Slippage.** HCS has been working with the National LeDeR Programme in order to join the national programme. The cost of joining the national programme is significant and likely to prevent us moving forward. MLRs are carried out for Learning Disability (LD) patients who die in hospital as an alternative measure. We are currently exploring other options including shadowing the LeDeR programme locally.

Priorities and Objectives	Status	Supporting Narrative
Priority 2: HCS will transform Maternity Services for a Brighter Future in Jersey		
Publication of the Maternity Improvement Plan 'Our Plan for the Way Forward with Maternity Services in Jersey' (strategy).		**On Track**. The Maternity Services in Jersey Strategy has been approved within HCS and is waiting for final approval by the HCS Advisory Board
Ensure processes are in place to ensure Safe Staffing across maternity.		**Complete**. A Birthrate plus review was completed in October 2023, with a final report provided in January 2024. Staffing levels are in line with birthrate plus and an escalation policy in place if required.
Create a collaborative culture of safety, learning and support through effective leadership.		**Complete**. Weekly Risk Meetings take place within Maternity, all safety events from previous week are discussed. Updates are given for all Serious Incidents (SIs) and learning is shared. Monitoring of actions and serious incidents occurs through Care Group Governance Meetings. A member of the senior leadership team attends the weekly Serious Incident Review Panel (SIRP) panels to embed any learning from other care groups. The Care Group has a fully established SLT, and all governance posts are recruited to. The continuous improvement culture is taking place in various guises.
Work with service users, staff, and community voices to shape our services.		**On Track**. Staff, service users and the Maternity Voices Partnership have all been involved in the development of the strategy; which is Phase 2 of the Maternity Improvement Plan. During Phase 2 there will be opportunity for families to come in for discussion. The Strategy has a 3-year implementation plan, so won't be completed till 2027.
Priority 3: Develop a Nutrition and Hydration Strategy for HCS		
Improve the visibility and governance of nutrition and hydration across HCS.		**Delayed.** The steering committee will reform in September 2024. Patient safety incidents and Serious Incidents related to this are monitored within the care groups and will feed into the steering group when it reforms.
Improve compliance and documentation of nutritional screening. NICE CG32: all adult inpatients should be screening for nutrition within 24 hours of admission, and all outpatients on first appointment.		**Delayed.** The EPR update is behind schedule, so this remains a paper-based assessment currently. The Malnutrition Universal Screening Tool has been a focus of care rounding. There appears to be an improvement in the compliance and documentation, but this will need to be formally audited.

Priorities and Objectives	Status	Supporting Narrative
Provide all inpatients with nutrition and hydration which meets their nutritional needs and dietary / cultural preferences in line with national standards for healthcare food and drink. BDA Digest: all healthcare menus must meet the nutrition standards for both nutritionally well and nutritionally vulnerable.		**Slippage.** Patient snack rounds are embedded in areas now, with patients reporting through 'care-rounds' that they have been offered supplementary snacks between meals. Work on the menus has not yet commenced.
Ensure appropriate and safe prescribing of oral nutrition support, enteral and parenteral nutrition.		**Slippage.** This work has been started but will need additional support to map and improve the process.
Priority 4: Inpatient Mental Health: Quality and Patient Experience		
Develop Quality Improvement plan.		**On Track**. A Quality Improvement Plan has been developed. There has been a delay in starting the work, but the new project manager will start in July 2024.
Improved service user experience measures.		**Delayed.** To be led by peer workers in Q3
Improved staff experience.		**On Track**. Staff workshop occurred in Q2; further work scheduled for Q3
Priority 5: Dementia and delirium within the General Hospital		
Reduce inappropriate use of sedation to manage distress and challenging behaviour.		**On Track**. Monthly audit of medication usage is in place. Each day the Head of Patient Safety and Lead Nurses receive a report from pharmacy detailing the administration of any rapid tranquilisation medication. The Lead Nurses then follow it up on the ward to ensure that they were used in the appropriate way. This is closely monitored through the Care Group Governance Meetings and Dementia Working Group.
Review clinical protocols / procedures in use.		**On Track**. The Delirium guideline is due to be ratified. The Enhanced Care Guidance and Rapid Tranquilisation policy have been ratified and implemented.
Dementia care audit completed.		**On Track**. HCS has signed the contract for the National Audit of Dementia due to take place in Q3 2024. A spot audit of all patients within the hospital was undertaken in July 2024, this included looking at the documentation and care planning.
Completion of carer survey.		**On Track**. This survey has been completed. Actions are to be allocated in July. The carers survey also forms part of the national audit.
Priority 6: Improve the management of the patient feedback processes and enhance patient experience		

Priorities and Objectives	Status	Supporting Narrative
Senior staff make sure every employee of HCS knows how they can create and deliver a just and learning culture for handling complaints, and that all staff can demonstrate how they contribute to this culture through practical example.		**On Track**. All Care Groups report monthly through the clinical governance and performance review meetings on PALS and complaints management. Learning categories are now added on the incident reporting system for each complaint. All future complaints will not be closed without this field having been completed. HCS routinely shares learning from complaints and PALS feedback with the GoJ to build on insight and best practice.
Staff respond to complaints at the earliest opportunity and consistently meet expected timescales for acknowledging a complaint.		**Delayed.** Monitoring is in place and complaints data is presented monthly at Care Group Performance Reviews and Governance Meetings. Achieving the 5-day Government of Jersey target is a challenge in a healthcare environment. The current average time to respond to stage 1 is 18 days, with the same period in 2023 being 51 days.
Staff give clear timeframes for how long it will take to investigate the issues considering the complexity of the matter, and clearly communicate this to complainants.		**Complete**. There is a Feedback officer now established in the role who liaises between the Care Group Investigators and complainants to ensure that complainants receive timely and correct information.
Implement Core Standards for the management of patient feedback across HCS.		**Delayed.** Care Groups are notified within 48 hours of a formal complaint. The PALS service has been fully launched in 2024, with a new office operational at the General Hospital's 'Parade' entrance. Posters and information have been put up to let patients know the process and who to contact. From July 2024
Priority 7: Staff Wellbeing		
Deliver a range of wellbeing initiatives for all HCS employees.		**On Track**. The offer of low intensity psychological support continues for all HCS staff. Trauma Risk Management (TRiM) support is also in place and available to all staff following an incident. There has been a recent cohort of 16 practitioners trained in TRiM to increase the capacity to provide timely wellbeing support for staff. Fifty senior leaders are being trained in the Coen Brown leadership model.

Culture and Workforce

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

Actions	Due	Status	Supporting Narrative
Our Culture			
Work environments are respectful and promote inclusiveness enabling safety to share information.	Q4 2024		**On Track**. The Freedom to Speak Up Guardian has enabled staff to report areas of concern. These have included bullying / harassment, inappropriate attitudes or behaviours, patient safety / quality and worker safety and wellbeing. Raising these issues with the Freedom to Speak Up Guardian allows them to be addressed and dealt with appropriately, enabling healthy work environments.
Improve multi-professional team working and collective decision making, escalating concerns when needed.	Q4 2024		**On Track**. The Civility Saves Lives (CSL) campaign was launched in January 2024. It will continue to be embedded alongside other cultural interventions throughout 2024.
Create better opportunities to safely learn and innovate and improve following incidents.	Q3 2024		**On Track**. Reviewing models of restorative and just practice for HCS continue. Safety huddles have been delivered with key stakeholders as an immediate action to enable post incident reflection.
Develop opportunities to safely reflect on professional practice.	Q4 2024		**On Track**. Monthly Schwartz Rounds are embedded and offer a safe space to reflect on professional practice. A pilot 'Psychological Safety in Healthcare Teams' was delivered in June 2024 to a cross-representative cohort of HCS staff. Training feedback will be assessed and incorporated into further training. The plan is to rollout training from September 2024, targeting employees working from identified services.

Actions	Due	Status	Supporting Narrative
Engage colleagues in understanding the Be Heard survey results & our initial proposed response to this so they can actively participate in developing & implementing the People & Culture plan.	Q3 2024		**On Track**. Senior Leaders for each HCS Care Group (Chief of Service, General Manager & Lead Nurse) have received a feedback session for their specific BeHeard results. Each Care Group have led the cascading of their own BeHeard results to HCS staff typically through inset / away-days. Progress continues with each Care Group developing their own People & Culture improvement plans with support of HR Consultant. A BeHeard pulse survey will be implemented in September 2024 providing an indicator of positive, neutral, or negative changes since June 2023.
Leadership and Management			
Executive Leadership to undertake leadership and management development, to support their teams in delivering sustainable models of high-quality care.	Q4 2024		**On Track**. The Leadership Development training programme has commenced and has already delivered training to several HCS senior leaders. Further training will continue throughout the rest of 2024.
Corporate team to deliver core leadership training programme to General Managers, Clinical Leads, Lead Nurses, Lead AHP's etc.	Q4 2024		**On Track**. The Leadership Development training programme has commenced and has already delivered training to several HCS senior leaders. Further training will continue throughout the rest of 2024.
Identify short / medium / long Term plans for all middle management development, including participation in World Class Manager sessions.	Q4 2024		**On Track.** It has been identified that there is need for a leadership development strategy for HCS. It should focus on first line managers, middle managers and senior managers and outline capability and competence requirements as well as access to training to support development. Development on this work will continue throughout 2024.
Engagement and Communications			
Continue delivering a range of listening events; Team HCS Talks, Be Our Best forums, Professional forums (MSC, Nursing & Midwifery, AHP), Schwartz Rounds, Breakfast with Chief Officer, ward/service walkarounds.	Q4 2024		**On Track**. Staff engagement has been enabled across a number of events throughout the year so far. These have included five 'Team HCS Talks', four Schwartz Rounds and four Breakfasts with the Chief Officer. Work will continue to build on these successes and enable more opportunities for staff to engage.

Actions	Due	Status	Supporting Narrative
Develop & implement regular Pulse Surveys.	Q1 2025		**On Track**. A Government of Jersey pulse survey will be implemented in September 2024. The HCS pulse survey will now be bi-annually rather than quarterly with the first to be implemented in March 2025.
Diversity and Inclusion			
Working Group has been created to develop anti-racism statement for HCS.	Q1 2024		**Complete**. A staff survey to understand racial discrimination in the workplace was implemented during Race Equality week (February 2024) and responded to by a proportion of HCS staff. An anti-racism statement and poster were co-created, and the anti-racism campaign launched in May 2024.
Use Working Group to develop wider strategy plan and key deliverables	Q4 2024		**On Track**. A diversity and inclusion development for HCS is in progress. A neurodiversity staff network was launched with an HCS staff forum.
Wellbeing			
Use established Culture Engagement and Wellbeing Committee to create and develop plan and key deliverables.	Q4 2024		**On Track**. Throughout the year so far staff wellbeing referrals continue to be received. Psychological support sessions have been delivered and wellbeing checks offered.
Strategic Workforce Plan			
Ensure engagement with PCS strategic workforce plan team at Care Group and Executive level.	Q1 2025		**On Track.** Strategic workforce plan underway with engagement from New Hospital Programme and People and Corporate Services who are working with HCS care groups. Executive engagement planned but not yet delivered. Delivery of plan likely to be Q1 2025.
Recruitment			
Continue the multi-approach method to recruitment.	Q4 2024		**Delayed.** Recruitment continues to be sub-optimal. A recruitment recovery plan will be developed by the end of Q3.
Develop recruitment pipeline metrics.	Q4 2024		**Delayed.** Manual methods of recording metrics are in place for non-medical recruitment and some progress has been made in medical recruitment. Work has commenced on developing metrics from the Connect People system. This work is likely to run into Q1 2025.
Engage with apprenticeship and internship programmes.	Q4 2024		**Delayed.** At this stage there is limited apprenticeship and intern activity and there is no delivery plan at this stage.

Actions	Due	Status	Supporting Narrative
Connect People			
Increase usage of Connect Performance through 2024.	Q4 2024		**Slippage.** Engagement with Connect performance is limited, staff structure errors and reconciliation problems between Connect Finance and Connect People are further hindering progress.
Utilise Connect Learning for delivery and recording of training.	Q4 2024		**Slippage.** Connect Learning has been implemented but there are significant issues with all staff being able to access the training.
Implement Connect People (Employee Central) for managers.	Q4 2024		**Slippage.** Connect People has been implemented but there are multiple issues with its usage relating to staff structure errors and reconciliation problems between Connect Finance and Connect People.
Implement Talent Acquisition for hiring new recruits	Q4 2024		**Slippage.** Talent Acquisition has been implemented but there are multiple process issues which are unresolved.
Support the Freedom to Speak up Guardian			
Regular meetings with CO and FTSU Guardian to resolve issues relating to employment matters.	Q4 2024		**On Track**. The Freedom to Speak Up Guardian has enabled staff to report areas of concern. These have included bullying / harassment, inappropriate attitudes or behaviours, patient safety / quality and worker safety and wellbeing.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Annual Plan 2024

Version Control

Status	Version	Sign-off Date	Changes
Draft	V0.1	25/01/2024	Final Draft for Board discussion
Approved	V0.2	29/02/2024	Final Draft for Board approval - Ministerial Priorities removed.
Approved	V0.3	28/03/2024	Final Draft for Board approval, with: 1. Additions: - New Sections: ○ Corporate Governance Structure ○ Commissioning - New ELT roles: ○ Director of Workforce and Financial Recovery Director 2. Amendments: - Departmental Structure: ○ Primary, Prevention, Therapies & Community Dental: moved from Chief Operating Officer – Acute Services to Director of Mental Health and Adult Social Care ○ Estates: moved from Chief Operating Officer – Acute Services to Director of Improvement and Innovation
Approved	V0.4	28/03/2024	Final Draft for Board, with: 1. Additions: a. Commissioning objectives
Approved	V0.5	30/05/2024	Additions: 1. New 'Common Strategic Policy' sub-section in previously titled 'Minister for Health and Social Services' section. 2. New vacant Director of Digital Health post in ELT. Amendments: 1. Minor amendment to BAF objective wording, as per V5 of the BAF. 2. 'Minister for Health and Social Services' section retitled as 'Ministerial'. 3. Corrections on some report dates within the 'Improvement Recommendations' section. 4. Advisory Board sub-committee titles updated.
Pending Approval	V0.6	25/07/2024	Amendments: 1. Meet the Team, page 5: Bill Nuttall removed and replaced by Ian Tegerdine as Director of Workforce (Interim). 2. New Healthcare Facilities, page 14: States Assembly funding debate: to secure finances to support the

			delivery of the first phases of the Programme - due date changed from Q2 2024 to Q4 2024. 3. New Healthcare Facilities, page 14: Submission of the Planning application for the revised plans to develop the Acute Hospital on the Overdale site - due date changed from Q2 2024 to Q3 2024 4. New Healthcare Facilities, pages 14: Programmes re-arranged in order of due date. 5. Digital Programme, pages 15-16: Due dates added to Projects. 6. Digital Programme, pages 15-16: Programmes re-arranged in order of due date. 7. Quality Account, pages 21 – 22: minor wording adjustments to priorities. 8. Culture & Workforce, page 24: Executive Leadership to undertake leadership and management development, to support their teams in delivering sustainable models of high-quality care – due date changed from Q2 2024 to Q4 2024 9. Culture & Workforce, page 24: Identify short / medium / long term plans for all middle management development including participation in World Class Manager sessions – due date changed from Q2 2024 to Q4 2024. 10. Culture & Workforce, page 24: Develop and implement ‘regular’ Pulse Surveys – ‘regular’ replaces ‘quarterly’. 11. Culture & Workforce, page 24: Develop and implement regular Pulse Surveys – due date changed from Q1 2024 to Q1 2025. 12. Culture & Workforce, page 25: Ensure engagement with PCS strategic workforce plan tea at Care Group and Executive level – due date changed from Q1 2023 to Q1 2024.

Contents

Foreword

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

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

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

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

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

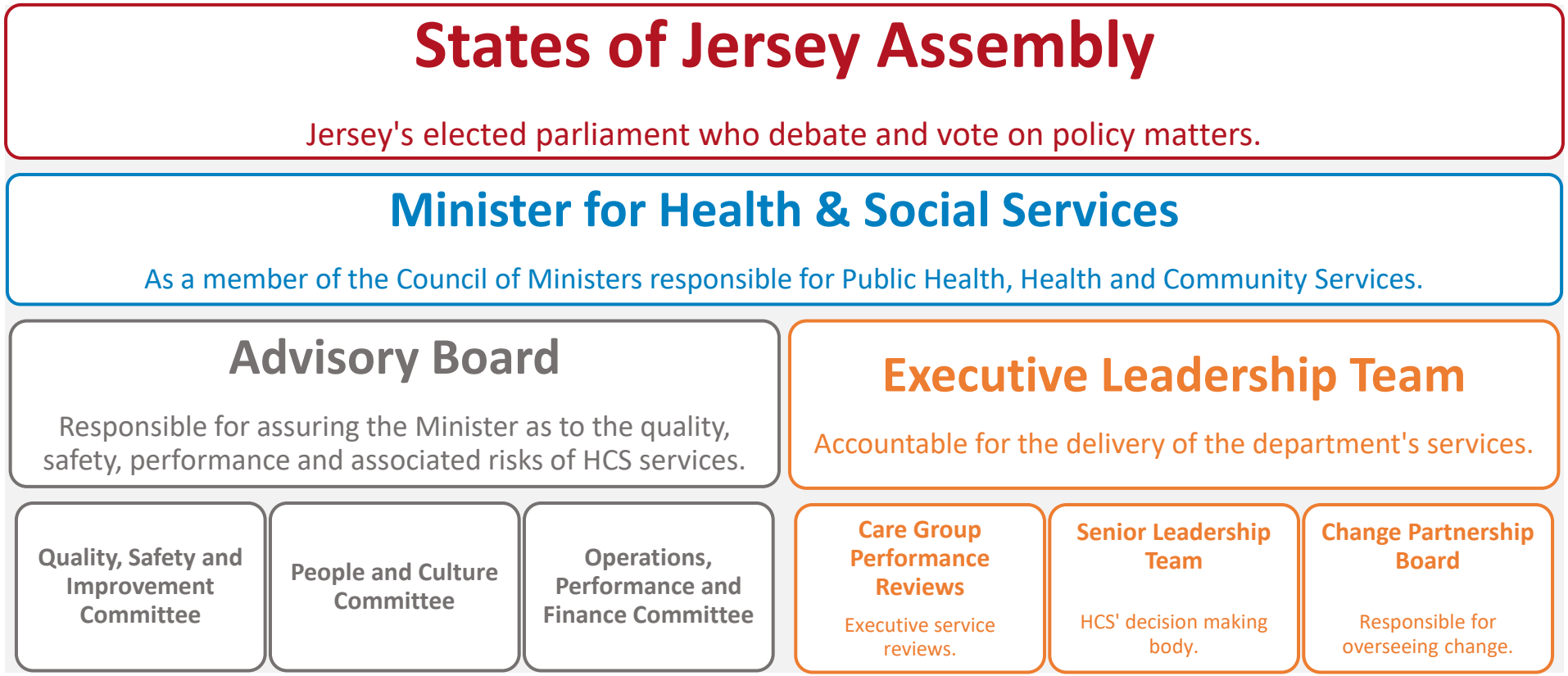
Every day, we aim to provide excellent care and support for Islanders that is centred around the patient / service user. We aim to offer a great place to work which is well-led and resourced, where we work with partners and colleagues to continuously improve the care, experience and outcomes for Islanders.

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

Chris Bown
Chief Officer, Health and Community Services

Corporate Governance Structure

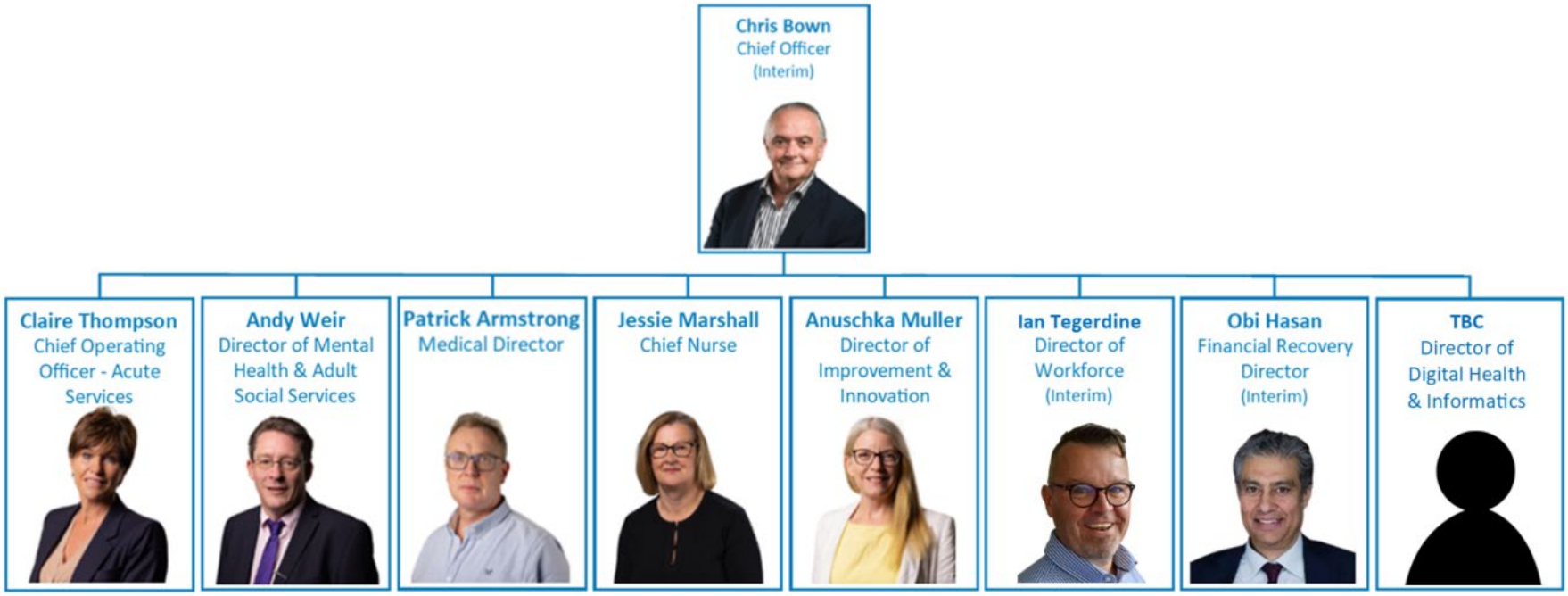
Governance is the means by which organisations make sure that decision-making is effective, risk is managed and the right outcomes are delivered. In HCS, this means delivering high quality services in a caring and compassionate environment whilst collaborating with partners.



Meet the Team

Executive Leadership Team

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



Senior Leadership Team

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

SLT is the decision-making body of the department.

Clinical

Simon West
Deputy Medical Director

Adrian Noon
Chief of Service - Medical Services

Simon Chapman
Chief of Service - Surgical Services

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

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

Paul Rendell
Chief Social Worker

Support

Cheryl Power
Director of Culture, Engagement and Wellbeing

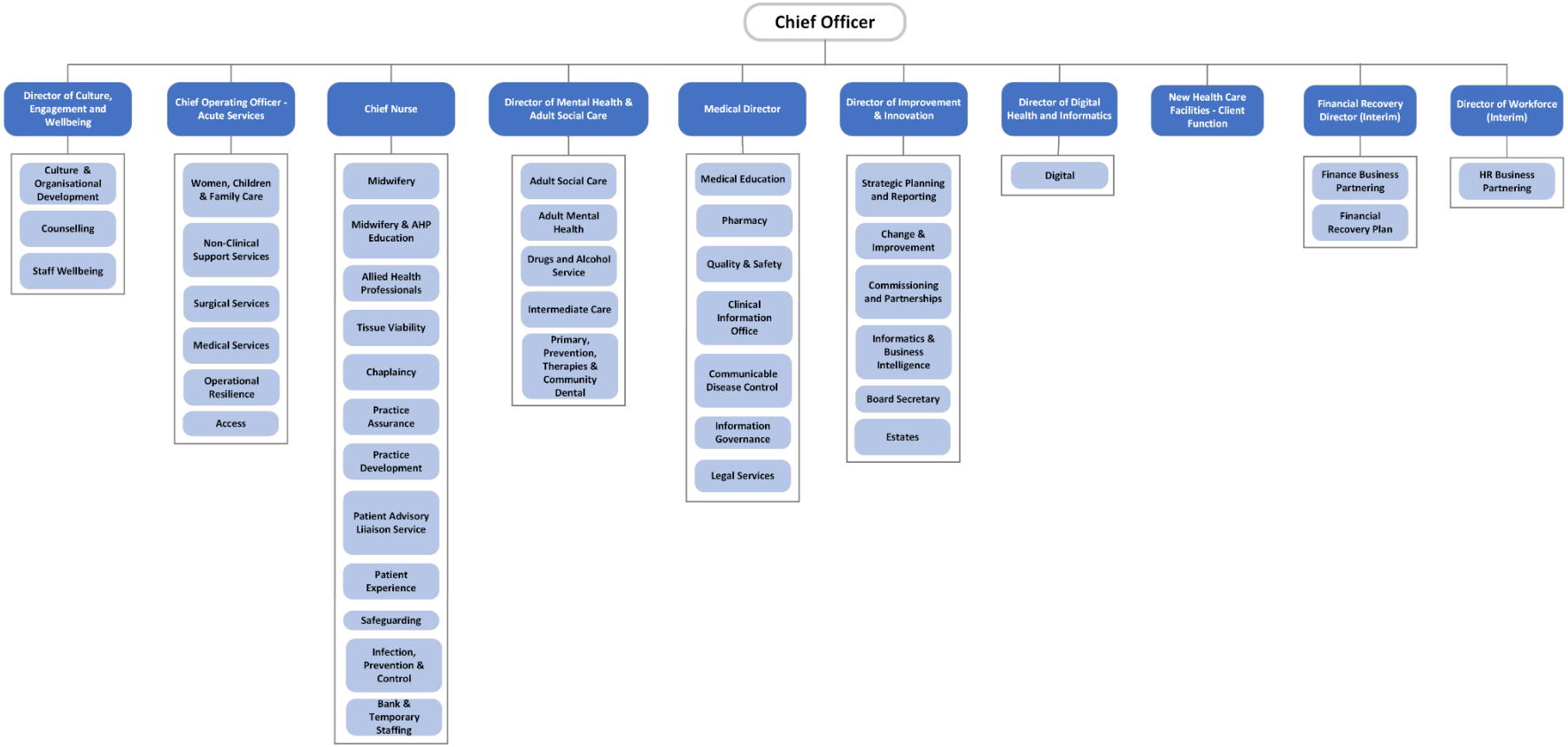
Sophia Bird
Head of Communications

Mark Queree
Deputy Head of Finance Business Partnering

Washington Gwatidzo
REACH Representative

Departmental Structure

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



Ministerial

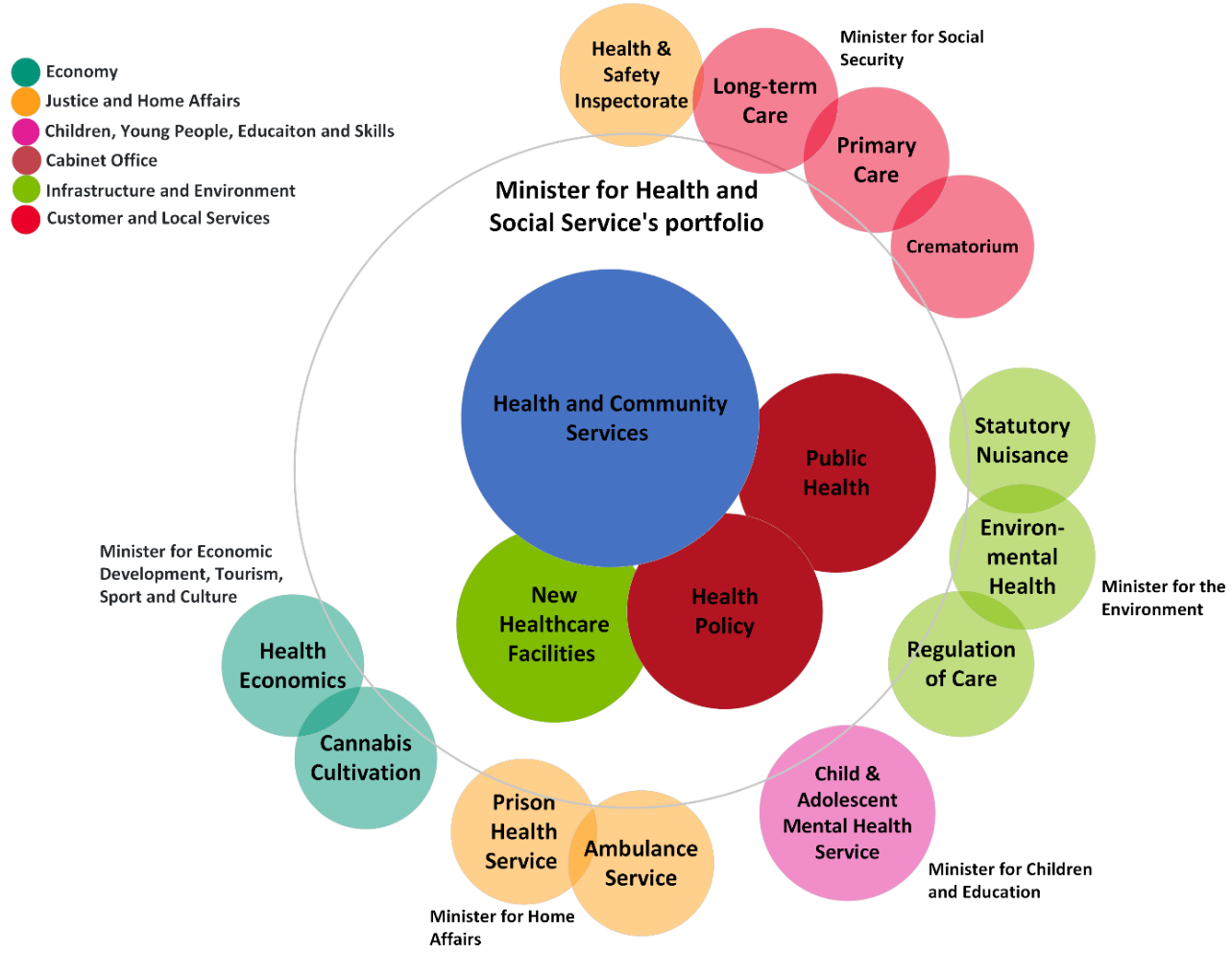
Common Strategic Policy

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

Minister for Health and Social Services' Portfolio

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

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



Board Assurance Framework

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

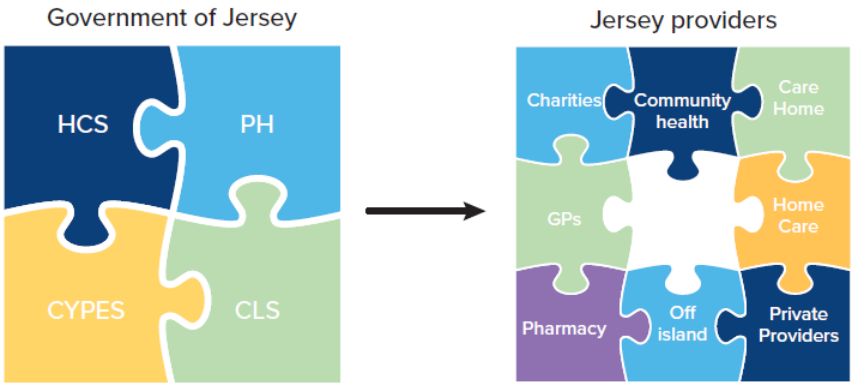
Objectives

Commissioning

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

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

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



How we will deliver

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

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

Improvement Recommendations

from C&AG, PAC, and Scrutiny Panels

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

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

Jersey Care Commission Preparation

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

Key Lines of Enquiry

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

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

How we will deliver

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

New Healthcare Facilities

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

Design

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

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

Clinical Input

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

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

How we will deliver

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

Existing Facility Maintenance

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

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

Digital Programme

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

Project	Detail	Due Date
Vendor Neutral Archive (VNA)	Implementation of a strategic method for clinical image storage, which improves efficiency and scalability.	Q1 2024
Obstetric Sonography System Software	Replace / upgrade the current ultrasound / scanning report application.	Q2 2024
Primary Care System review	Review the current Primary Care system solution and establish requirements for re-tender.	Q2 2024
General Practitioner (GP) Order Comms	To replace the paper-led requesting and reporting process which will reduce result turnaround times, provide a fully audited service.	Q3 2024
Jersey Health & Care Index (HCI)	An essential project to ensure consistency of patient data.	Q3 2024
Faecal Immunochemical Testing (FIT)	To digitally support the FIT booking and screening process which will increase the number of patients who can be screened - improving detection and treatment.	Q3 2024
Picture Archiving & Communications Systems (PACS)	Replacement of a legacy system, with migration of images and image reporting history. Will also provide clinical image reporting services.	Q3 2024
Audiology: Audit Data replacement for Practice Navigator	Replace legacy system.	Q3 2024
Ophthalmology Electronic Patient Record (EPR)	Implementation of a new EPR system to create automation and efficiencies, to deliver shorter waiting times.	Q3 2024
IT Service Model review for commissioned services	Ensuring compliance with IT infrastructure standards and contractual arrangements.	Q4 2024
Electronic Patient Medicines Administration (EPMA)	Deployment of infrastructure, to improve clinical compliance and safety.	Q4 2024
Sexual Health Clinic Electronic Patient Record (EPR)	To capture structured clinical data and remove the current paper-based process.	Q4 2024
Hospital Electronic Patient Record (EPR)	Replacement or update of current General Hospital EPR system	Q4 2024
Cervical Cancer Screening	An essential upgrade to support the service in achieving screening targets, through increased efficiency and automation.	Q4 2024

Project	Detail	Due Date
e-Consent for surgical procedures	A system that enables patients to provide their consent online.	Q4 2024
Virtual Consultations	Enable virtual consultations to improve waiting times by providing Consultant led services remotely.	Q4 2024
Essential Hospital Wi-Fi	To improve connectivity in the hospital.	Q4 2024
Electronic Record System for Adult Social Care	Transformation of the system and processes to meet the service's needs.	Q1 2025
e-Referral Process	Implement a solution to replace the predominantly email led referral process.	Q2 2025
e-Prescribing Chemotherapy	To reduce clinical risk and comply with best practice.	Q2 2025

Quality and Performance Metrics

Quality and Performance Report & Service Performance Measures

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

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

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

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

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

Financial Recovery Plan

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

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

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

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

Workstreams

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

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

Forecast Savings

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

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

Quality Account

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

Quality in healthcare is made up of four core dimensions:

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

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

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

2024 Priorities

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

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

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

Culture and Workforce

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

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

	Goals	Actions	Due	Success Measures
Leadership and Management Development	a. Our Values, Our Behaviours are visible and demonstrated throughout all levels of leadership & management. a. Leaders have clear leadership objectives. b. Managers are developed and invested in through formal qualifications/GoJ manager training/mentoring.	Executive Leadership to undertake leadership and management development, to support their teams in delivering sustainable models of high-quality care.	Q4 2024	• Improved performance (managers responding to issues). • Increase in Connect Performance returns (with SMART objectives and progress). • Reduced number of dignity & respect grievances.
		Corporate team to deliver core leadership training programme to General Managers, Clinical Leads, Lead Nurses, Lead AHP's etc.	Q4 2024 and ongoing throughout 2024.	
		Identify Short/Medium/Long Term plan for all middles management development including participation in World Class Manager sessions.	Q4 2024	
Engagement and Communications	a. Continue staff engagement following Be Heard survey through regular listening events and pulse surveys. Ensure colleagues are aware of & feel engaged with the development & delivery of the People & Culture plan. b. Improve engagement & communication, including understanding HCS purpose, the strategic plan and care group/service priorities. c. Ensure the communications for the HCS People & Culture plan & the individual care group People & Culture plans are connected & aligned to HCS vision and objectives.	Continue delivering a range of listening events; Team HCS Talks, Be Our Best forums, Professional forums (MSC, Nursing & Midwifery, AHP), Schwartz Rounds, Breakfast with Chief Officer, ward/service walkarounds.	Ongoing throughout 2024.	• Increased staff engagement. • Improved staff collaboration & connection. • Smarter decision making. • Improved performance.
		Develop & implement regular Pulse Surveys.	Q1 2025	

Diversity and Inclusion	a. Create a Diversity and Inclusion plan for HCS.	Working Group has been created to develop anti-racism statement for HCS. Use working group to develop wider strategy, plan & key deliverables.	Anti-racism statement to be launched alongside Civility Saves Lives programme Quarter 1 2024.	• D&I plan. • Reduced numbers of dignity & respect grievances. • Improved workplace relationships. • Improved performance. • Greater readiness to innovate & improve.
Wellbeing	a. Continue wellbeing support for colleagues across HCS aligned with NICE guidance; 'Mental Wellbeing at Work'.	Use established Culture, Engagement & Wellbeing committee to create & develop plan & key deliverables.	Ongoing throughout 2024.	• Increase in wellbeing engagement factors. • Reduced sickness absence rates. • Reduced anxiety/stress related absence. • Improved performance.
Strategic Workforce Plan	a. Produce a strategic workforce plan for HCS	Ensure engagement with PCS strategic workforce plan team at Care Group and Executive level.	Q1 2025.	• Understanding of emerging capabilities and skill requirements. • Development of a plan to meet future needs and mitigate risk. • Identification of areas requiring succession planning and training requirements.
Recruitment	a. Increase number of substantive employees. b. Reduce reliance on agency and locum workers.	1. Continue the multi-approach method to recruitment. 2. Develop recruitment pipeline metrics. 3. Engage with apprenticeship and internship programmes.	Ongoing throughout 2024.	• Reduced vacancy numbers and reduced agency numbers. • Increased numbers of interns and apprentices.

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

Health and
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Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**HCS' 2025 Planning Approach**		
Date of Meeting:	25th July 2024	**Agenda Item:**	**16**

Executive Lead:	Anuschka Muller, Director of Improvement and Innovation
Report Author:	Harry Hambrook, Senior Business Planner

Purpose of Report:	Approval √	Assurance ☐	Information ☐	Discussion ☐
	To present the three options for departmental planning which were discussed by HCS' Senior Leadership Team (SLT) on 11th July and to seek support for HCS SLT's preferred option.			
Summary of Key Messages:	Being half-way through the year, we need to start planning for the 2025 HCS annual business plan. It is important that we consider the 'well-led' requirements of the Jersey Care Commission's 'single assessment framework' in developing the plan. For HCS' planning documents to meet the Jersey Care Commission (JCC's) requirements, two documents are required: a strategy and a delivery plan. The Board is asked to decide whether they support the HCS' Senior Leadership Team's decision to develop: 1. An annual business plan for 2025, as well as 2. A three / four-year strategy (2026 – 2027/28)			
Recommendations:	The Board is asked to note and support the HCS' SLT in developing option 3.			

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

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
HCS Senior Leadership Team	11th July 2024	Approved

List of Appendices:
None.

MAIN REPORT

In Q4 2023, HCS developed the 2024 Annual Plan, which is a high-level document that sets out HCS' five objectives, and key areas of delivery for 2024 and how we monitor and report on service performance.

We are now half-way through 2024 and need to start planning for next year's plan so that this is ready for a November 2024 Board sign off.

'Well led' is one of the Key Elements of Care (KEC) within the JCC's draft 'Single Assessment Framework'. 'Well-led' covers 'Standard 28 – Shared Direction and Culture', which sets out what care providers should have in place with regards to a strategy / plan. Developing an enhanced strategy / plan is an opportunity to address and fulfil this requirement.

The relevant 'universal requirements' of the draft 'single assessment framework' are:

- 28.1.1 The care provider has a well-defined vision and values statement.
- 28.1.2 The strategy and plan for delivery are coherent with the care provider's vision and set out clear objectives and timescales.
- 28.1.3 Vision and strategy are collaboratively developed with input from service users, staff, and system partners.
- 28.1.4 The strategy is grounded in a clear understanding of the quality of care, improvement, finances, operational realities, and performance.
- 28.1.5 Explicit attention is given to addressing challenges in the workforce, estates, and information technology.
- 28.1.6 Clear leadership accountability is established for each component of the care provider's strategy and plan.
- 28.1.7 Joined up strategies and plans with key system partners are in place where appropriate.
- 28.1.8 It is clearly set out how the care provider will monitor and review delivery of its objectives.

HCS' 2024 Annual Plan meets a number of the requirements however, it falls short with regards to vision, explicit explanation of the challenges and realities, explaining and evidencing joined up strategies with partners. In essence, it is an annual plan, not a strategy.

To develop a multi-year departmental vision and strategy, we would need a document that is, most importantly, *collaboratively developed with input from service users, staff, and system partners*.

Regardless of the approach taken to next year's planning document, the following needs to be undertaken:

- update the Service Performance Measures so that they align better against the BAF objectives,
- develop a planning framework that sets out how strategic objectives follow through to deliverables for services, and

- develop the document more collaboratively.

HCS' SLT met on 11th July and agreed that our preferred option, is option 3 below.

Option 1: Annual business plan for 2025.

The 2024 document could be used as a basis for discussion and development of the 2025 plan; based on Board feedback, clear deliverables against the objectives and metrics to measure should be included. Requirements of the JCC's 'single assessment framework that can easily be included, such as focus on better explanation and linkage of objectives to deliverables, will enhance the plan.

Option 2: A three-year strategy, and a delivery plan for 2025.

Development of two distinct documents; a strategy and a delivery plan. It should be noted that the strategy would be a departmental strategy not a health-system strategy. The strategy would set HCS' vision and objectives whilst the delivery plan for 2025 would define deliverables and metrics against the strategy.

However, strategy development is mainly an engagement exercise and requires a variety of stakeholders to be involved. Engagement sessions need to be well prepared and facilitated, set up in advance and supported with insightful data and future scenarios for consideration. Realistically, this would not be achievable in the desired timeframe (Sept for Nov sign off).

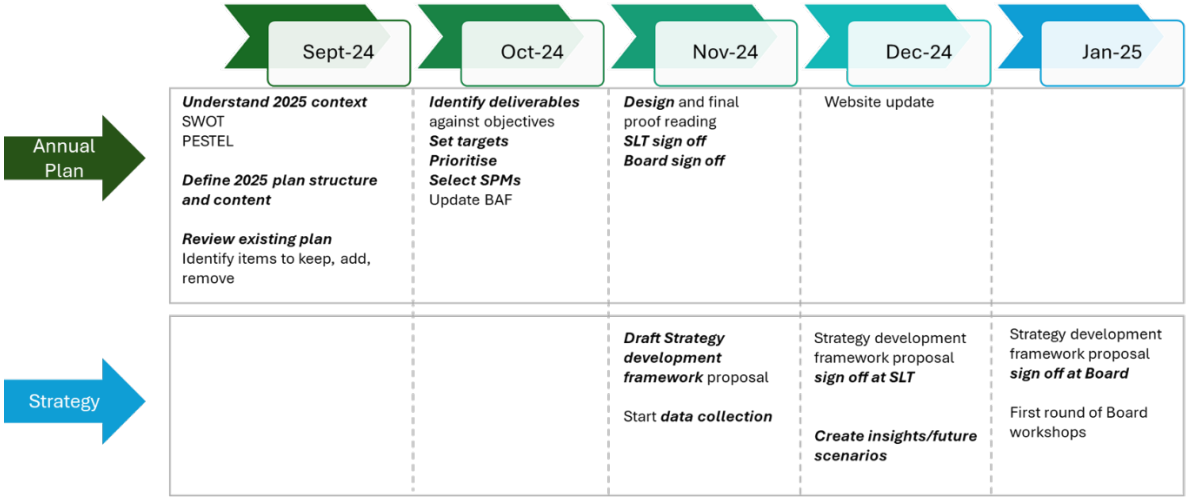
Option 3: Annual business plan for 2025 and start to develop a three- or four-year strategy (2026 – 2027/2028)

As option 1 but with a committed start to work on a three- to four-year strategy 2026 - 2027 / 2028. Annual plan development would be undertaken in Sept-Oct 2024 with sign off in Nov for Jan-25 start. Strategy development would commence in Nov-24 with sign off in Nov-25 for a Jan-26 start.

This offers an opportunity to continue building a collaborative culture with staff, service users and system partners. Engagement would ensure that JCC requirements are being meet, including alignment of strategy with those of other health providers. It would result in a medium-term strategy for HCS supporting the Board in monitoring delivery of service improvements and driving excellence in care.

In addition, it would have the advantage to get strategy sign off from the permanent HCS Board (subject to approval of the States Assembly in March 2024).

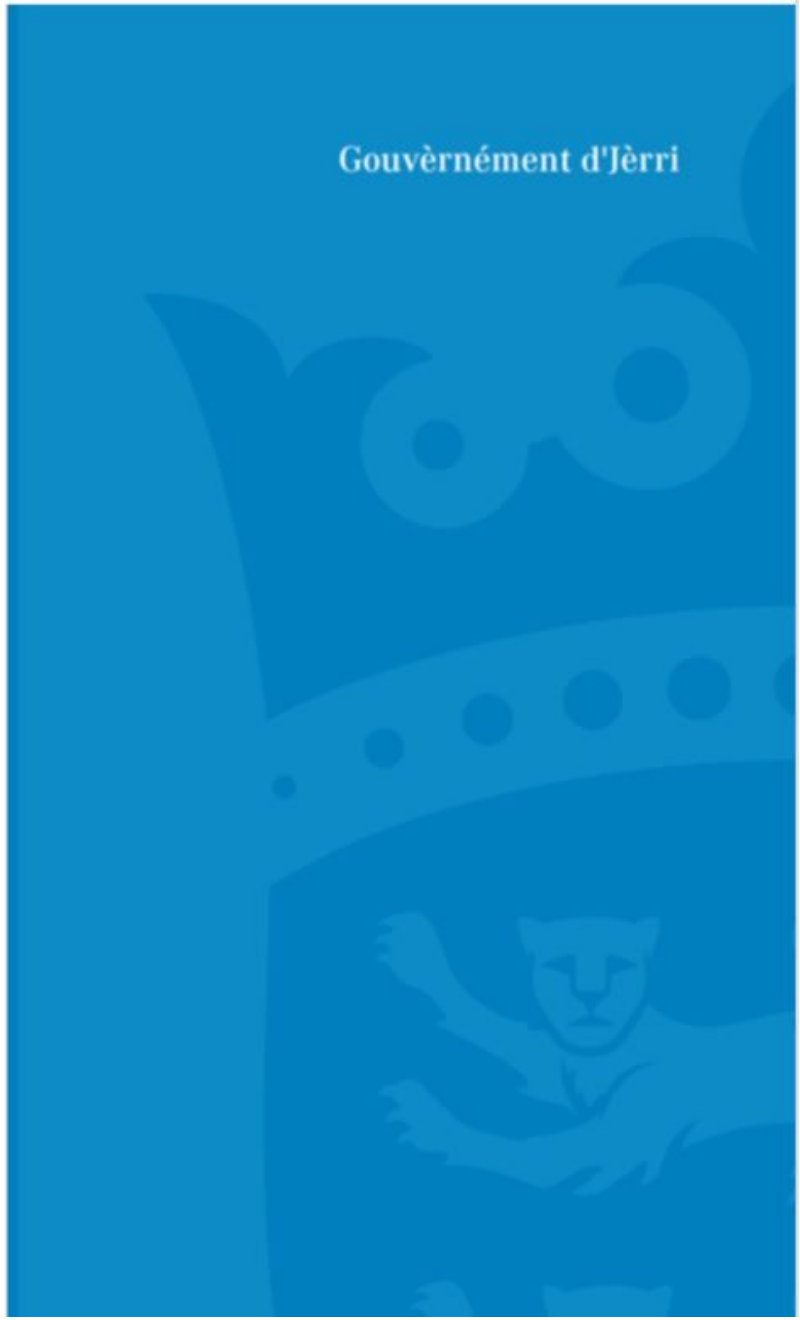
High-level timeline and process for option 3



END OF REPORT

Health and Community Services

Quality and Performance Report
June 2024



Health and Community Services

INTRODUCTION

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

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

SPONSORS:

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

DATA:

HCS Informatics

Health and Community Services

STATISTICAL PROCESS CONTROL (SPC) CHARTS

WHAT ARE SPC CHARTS?

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

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

HOW TO READ SPC CHARTS

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

Elective Care Performance

Section Owner

Chief Operating Officer – Acute Services

Performance Narrative

Outpatients waiting over 52 weeks for 1st appointment

Patients waiting over 52 weeks for their first appointment continues to fall. All long wait patient referrals have been reviewed and we continue to allocate appointments based on clinical urgency as defined by the triaging consultant. The specialties where outpatient capacity does not meet the demands of referrals, and thus longer waits are experienced by the patients continue to be dermatology, ophthalmology, gastroenterology and ENT. However, all urgent referrals are being seen within an appropriate timescale.

A brief paper will be discussed at HCS Advisory Board to highlight the future for improved capacity and service redesign for dermatology to deliver improved access for patients in the longer term.

Elective inpatient waits over 52 weeks

Patients waiting over 52 weeks for their elective procedure have fallen again from the last report presented to the board. At the end of M4, the number of patients waiting over 52 weeks was 276, at the end of M6, the number of patients is 264. Orthopaedics and General Surgery continue to have the longest waits for our patients.

Diagnostic Waits over 6 weeks

Diagnostic waits continue to rise within endoscopy and MRI. As described previously, the successful pilot of the MRI increased capacity has now been adopted with recruitment to the newly funded posts continuing. Once this additional substantive capacity is in place, the waiting times for MRI will reduce. Within endoscopy, the waiting list initiative earlier in the year proved successful, however capacity has since reduced whilst we wait for the new substantive consultant to commence in post at the end of July. The planned WLI for endoscopy was unable to be progressed due to lack of clinical resource to undertake the procedures.

Elective Care Performance

New to Follow-up ratio

New to follow-up ratio remains at an acceptable rate across most specialties and continues to be monitored.

DNA rate

The DNA rate remains static at around 11% for the first half of the year. Ongoing work across outpatient improvement will ultimately support reductions in DNA rate, this includes process redesign and digital initiatives which have a longer-term implementation timescale.

Elective Theatre Utilisation

Theatre utilisation has improved for the 7th month in a row, however, remains below the acceptable standard. Ongoing theatre improvement work, process redesign, education and training continue to have positive impact. Further intensive work across Q3 will provide further improvements in utilisation.

Was Not Brought Rate

This rate is consistent with the DNA rate and forms part of the outpatient improvement work.

Operations Cancelled for Non-Clinical Reasons

Cancelled operation numbers continue to remain static. Reduction in cancellations form part of the theatre improvement work which is ongoing.

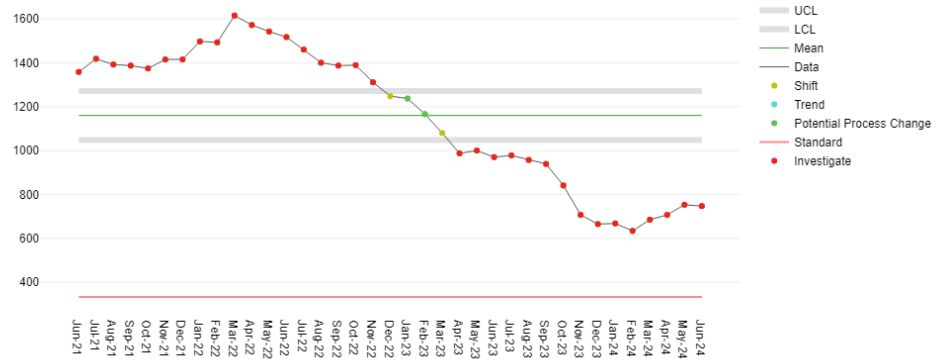
Escalations

No Escalations

Elective Care Performance - SPC Charts

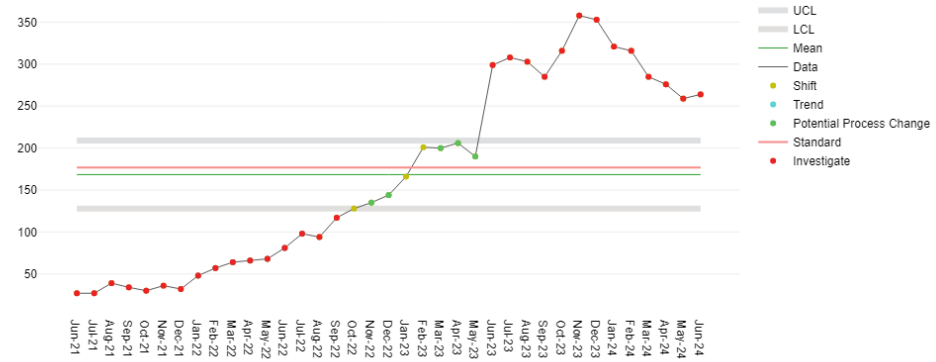
Latest value	Standard
747	<333

Patients waiting for first outpatient appointment Greater Than 52 weeks



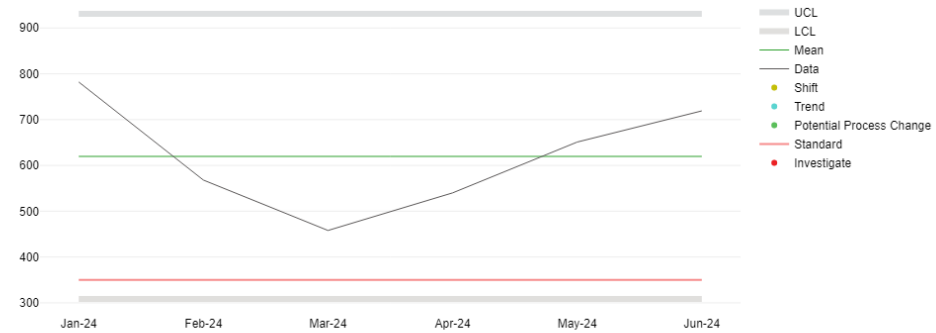
Latest value	Standard
264	<177

Patients on elective list Greater Than 52 weeks



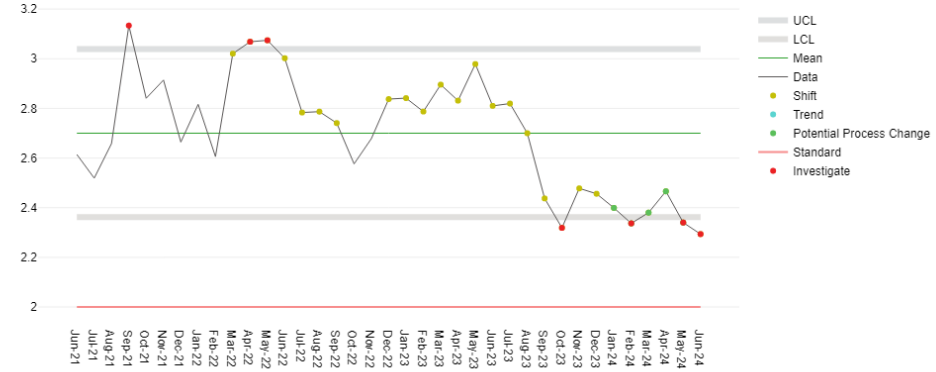
Latest value	Standard
719	<350

Access to diagnostics Greater Than 6 weeks



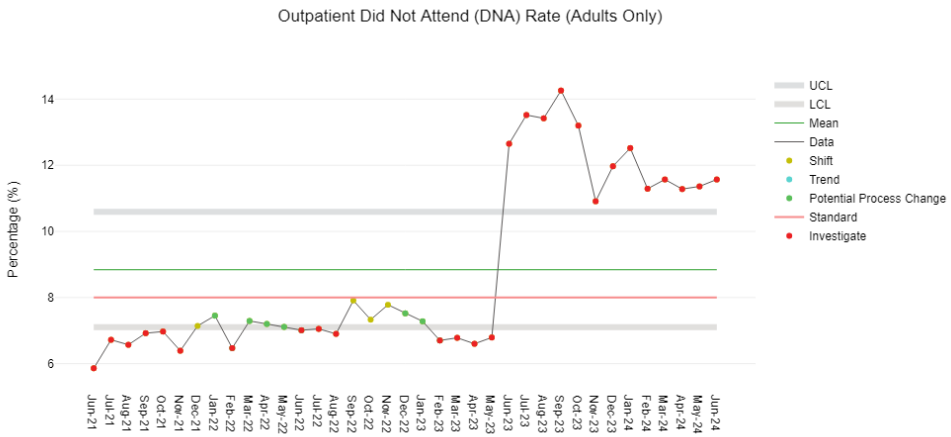
Latest value	Standard
2.29	2

New to follow-up ratio

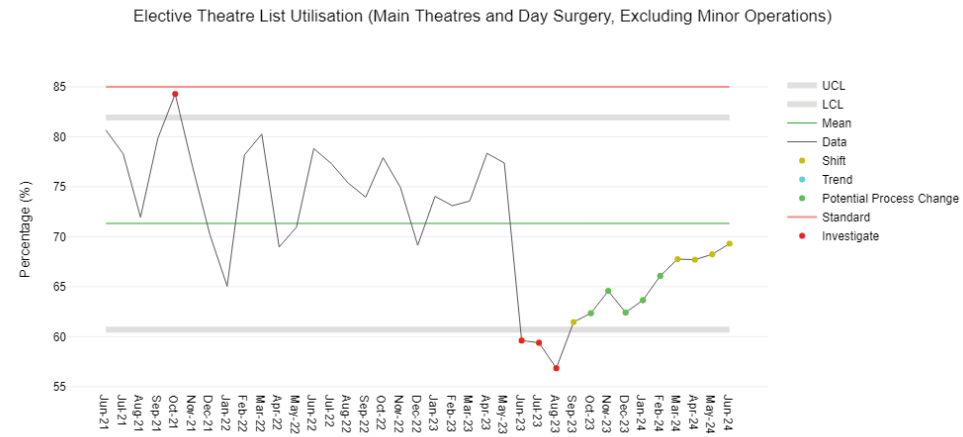


Elective Care Performance - SPC Charts

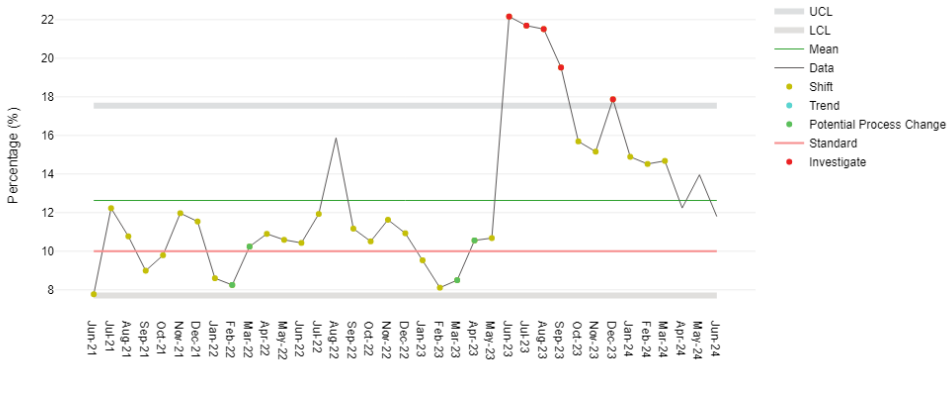
Latest value	Standard
11.6 %	<=8%



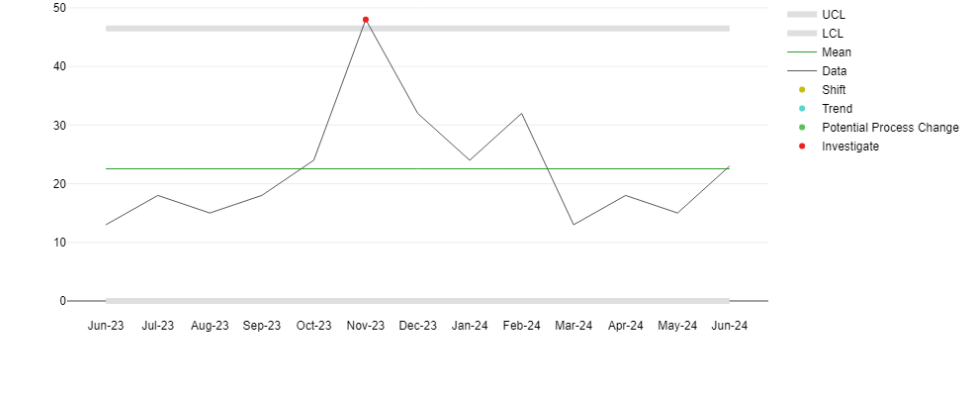
Latest value	Standard
69.3 %	>85%



Latest value	Standard
11.8 %	<=10%



Latest value	Standard
23	NA



Elective Care Performance - Indicator & Standard Definitions

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

Emergency Care Performance

Section Owner

Chief Operating Officer – Acute Services

Performance Narrative

An increase of 0.4% has been noted in patients waiting over 12 hours in the Emergency Department (ED) compared to the month of May. Out of 3992 who attended ED in June, 75 waited over 12 hours of which 40 were admitted and 35 were discharged. We continue to work on our flow improvement and embed Red2Green (R2G) principles.

We continue to face challenges in relation to longer waits in ED with the main drivers of this including isolation, ensuring same sex bays, and general capacity. As part of the Clinical Productivity workstream, actions to support the improvement of patient experience are included in the clinical flow improvement strategy.

We still are seeing low numbers of patients being moved out of hours for non-clinical reasons. We continue to prioritise bed movements earlier in the day.

Reduction in emergency length of stay has been noted in June compared to April and May due to the implementation of Long Length of Stay multi-disciplinary meetings. This is our continued response to the Royal College of Physicians report and operational workstream.

The emergency readmission rate has risen again in month. Analysis of the reasons shows no theme at this stage, however more in depth work to identify any actions is required.

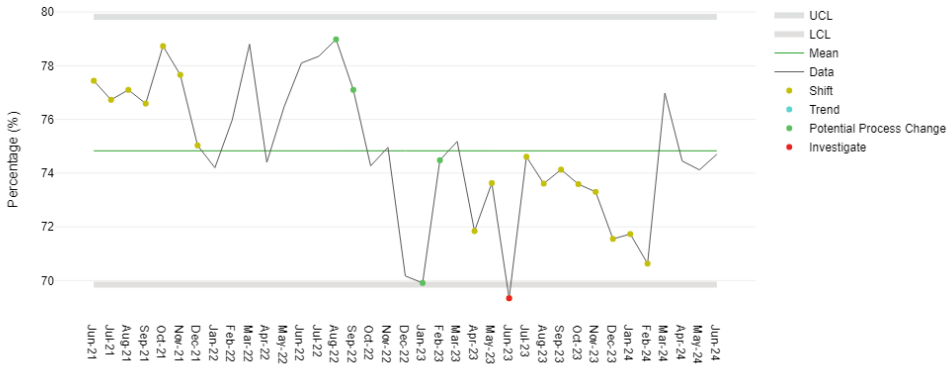
Escalations

No Escalations

Emergency Care Performance - SPC Charts

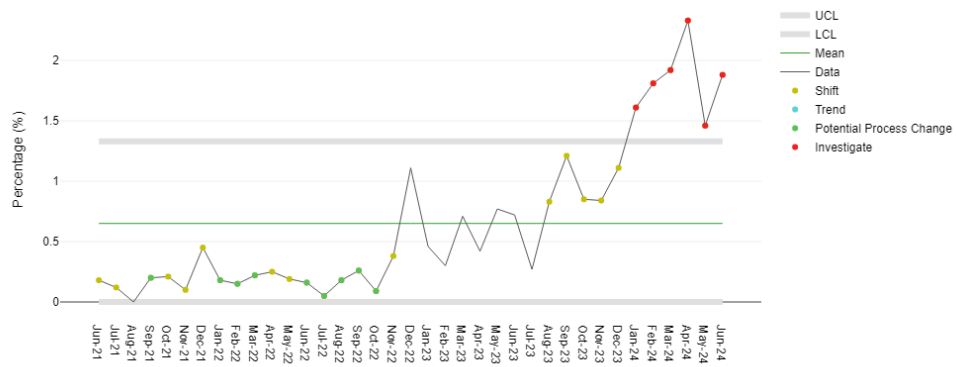
Latest value	Mean
74.7 %	74.8 %

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



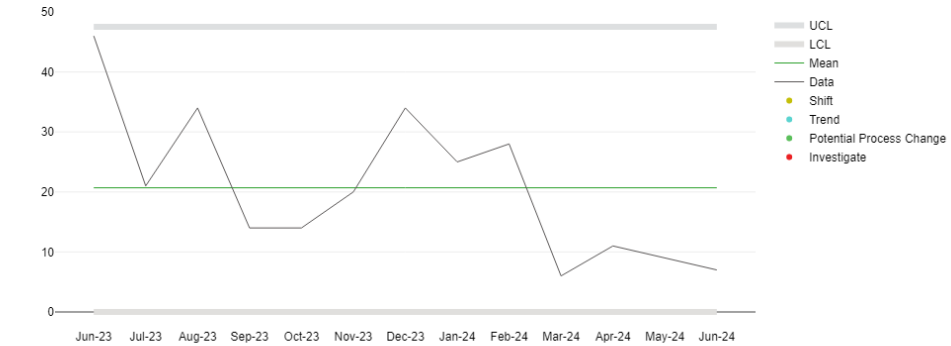
Latest value	Mean
1.9 %	0.7 %

% Patients in Emergency Department for more than 12 Hours



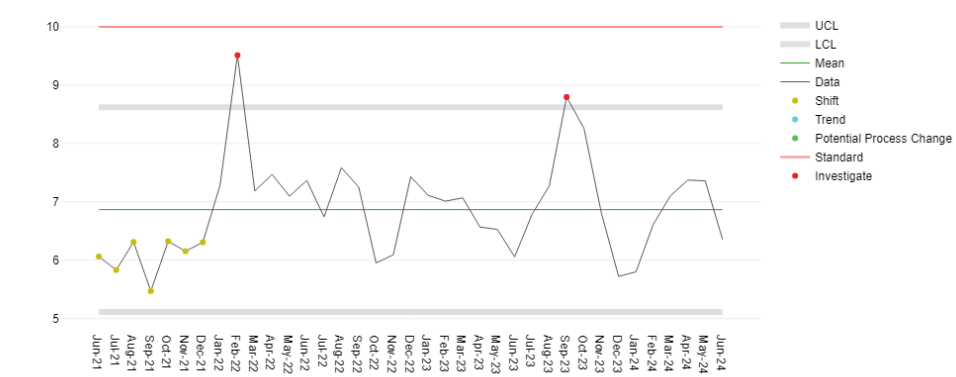
Latest value	Mean
7	20.69

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



Latest value	Mean
6.36	6.87

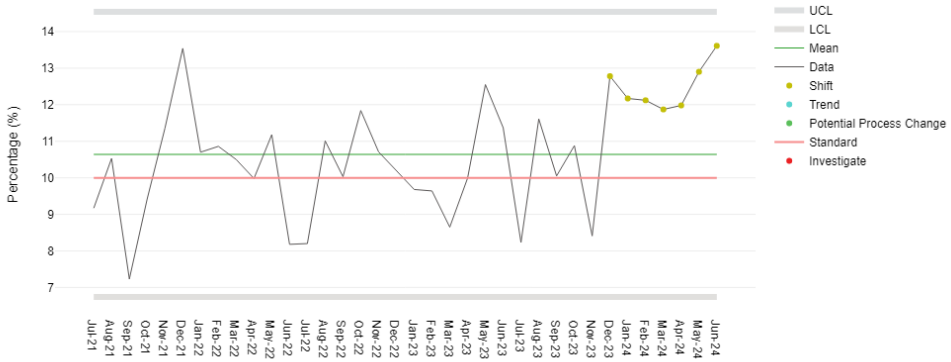
Non-elective acute Length of Stay (LOS) (days)



Emergency Care Performance - SPC Charts

Latest value	Mean
13.6 %	10.6 %

Rate of Emergency readmission within 30 days of a previous inpatient discharge



Emergency Care Performance - Indicator & Standard Definitions

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

Maternity

Section Owner

Chief Nurse

Performance Narrative

Our caesarean rate in month was 52.24% (36 /69), we saw an increase in our primigravida single pregnancies requesting (and having) a caesarean section, this being 14 out of the 36 women who had a caesarean in month. Patient choice continues to play a key part our caesarean section rate which is in line with both UK national and international trends. We had no caesarean births at full dilatation.

Our induction rate remains consistent month on month at 19.4%, which is evident that we are ensuring we are offering induction at the correct gestation due to the presenting clinical picture.

Breastfeeding initiation remains good at 71% with mothers choosing to breast feed. We are prepared for International Breastfeeding week on 1st-7th August 2024.

There has been an increase in shoulder dystocia in month, but these are all reviewed and are well managed with appropriate manoeuvres.

Maternity - Key Performance Indicators

Indicator	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	YTD
Total Births	58	80	72	67	58	66	59	67	51	58	56	53	69	354
Mothers with no previous pregnancy (Primips)								24	15	20	16	20	34	129
Mothers who have had a previous pregnancy (Multips)								26	19	30	28	23	25	151
Mothers with unknown previous pregnancy status								17	17	8	12	10	10	74
Bookings ≤10+0 Weeks								6	3	7	8	8	9	41
% of women that have an induced labour	23.21%	20.27%	27.78%	31.25%	17.24%	30.77%	38.98%	30.16%	24%	31.58%	22.22%	16.67%	19.4%	24.19%
Number of spontaneous vaginal births (including home births and breech vaginal deliveries)	23	26	25	23	21	18	11	25	13	22	10	19	19	108
Number of Instrumental deliveries	6	5	12	4	5	5	4	7	3	5	2	3	7	27
% deliveries by C-section (Planned & Unscheduled)	30.36%	44.59%	44.44%	37.5%	46.55%	49.23%	45.76%	36.51%	52%	40.35%	66.67%	45.83%	52.24%	48.67%
% Elective caesarean section births	21.43%	22.97%	22.22%	21.88%	22.41%	27.69%	28.81%	23.81%	32%	15.79%	37.04%	27.08%	29.85%	27.43%
Number of Emergency Caesarean Sections at full dilatation	1	0	1	1	1	2	0	2	1	1	1	1	0	6
Number of women in Robson Group 1 cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, spontaneous labour)								2	3	0	8	2	7	22
Number of women in Robson Group 2a cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, induced labour)								4	3	5	5	1	4	22
Number of women in Robson Group 2b cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gesation, caesarean birth prior to onset of spontaneous labour)								3	3	2	5	3	7	23
Number of women in Robson Group 5 cohort (Previous caesarean birth, single cephalic pregnancy, at least 37 weeks' gestation)								4	6	5	6	4	4	29
Number of deliveries home birth (Planned & Unscheduled)	4	2	4	2	3	3	0	2	3	1	1	1	1	9
Mothers who were current smokers at time of booking (SATOB)	2	4	0	1	4	3	2	7	7	3	4	6	2	29
Mothers who were current smokers at time of delivery (SATOD)	0	0	0	0	1	0	0	0	1	3	0	2	2	8

Maternity - Key Performance Indicators

Indicator	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	YTD
Number of Mothers who were consuming alcohol at time of booking	1	3	1	1	2	0	3	1	1	2	0	0	0	4
Number of Mothers who were consuming alcohol at time of delivery	0	0	0	0	0	1	0	7	4	6	4	3	4	28
Breastfeeding Initiation rates	81%	73.8%	76.4%	77.6%	74.1%	75.8%	72.9%	79.1%	74.5%	65.5%	73.2%	69.8%	71%	72.32%
Transfer of Mothers from Inpatients to Overseas	0	0	0	0	0	2	1	0	3	1	1	0	1	6
Number of births in the High dependency room / isolation room	1	0	0	1	0	0	0	1	1	0	0	0	0	2
Number of PPH Greater Than 1500mls	3	4	2	3	6	6	3	2	2	1	6	0	1	12
Number of 3rd & 4th degree tears – all births	3	1	1	2	2	1	0	2	2	1	0	0	0	5
% of babies experiencing shoulder dystocia during delivery	1.72%	2.5%	2.78%	1.49%	1.72%	0%	1.69%	0%	0%	0%	1.79%	0%	4.35%	1.13%
% Stillbirths Greater Than 24 Weeks Gestation								0%	0%	0%	0%	0%	0%	0%
Neonatal Deaths at Less Than 28 days old								0	0	0	0	0	0	0
Number of babies that have APGAR score below 7 at 5 mins	0	0	0	1	0	1	0	0	1	0	1	1	1	4
% live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA)	0%	4%	2.7%	0%	9.09%	5%	3.45%	0%	3.7%	7.41%	3.85%	7.14%	2.78%	3.95%
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation	0	0	0	0	0	2	2	0	1	0	0	1	2	4
Transfer of Neonates from JNU	0	1	0	0	0	1	1	1	0	0	1	0	1	3
Preterm Births ≤27 Weeks (Live & Stillbirths)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Preterm Births ≤36+6 Weeks (Live & Stillbirths)	0	6	2	2	7	1	2	1	1	8	1	2	2	15
Neonatal Readmissions at Less Than 28 days old								11	4	4	5	5	4	33

Maternity - Indicator & Standard Definitions

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

Maternity - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Number of women in Robson Group 2a cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, induced labour)	Hospital Patient Administration System (Maxims, Caesarean Deliveries Report MT008DM)	Indicator is for information only	A woman who hasn't previously given birth, baby is bottom and feet up with their head down near the exit, or birth canal, facing the mother's back. Baby is at full term and labour was started artificially.
Number of women in Robson Group 2b cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gesation, caesarean birth prior to onset of spontaneous labour)	Hospital Patient Administration System (Maxims, Caesarean Deliveries Report MT008DM)	Indicator is for information only	A woman who hasn't previously given birth, baby is bottom and feet up with their head down near the exit, or birth canal, facing the mother's back. Baby is at full term and baby was delivered via elective caesarean section.
Number of women in Robson Group 5 cohort (Previous caesarean birth, single cephalic pregnancy, at least 37 weeks' gestation)	Hospital Patient Administration System (Maxims, Caesarean Deliveries Report MT008DM)	Indicator is for information only	A woman who has previously given birth via caesarean section, baby is bottom and feet up with their head down near the exit, or birth canal, facing the mother's back. Baby is at full term.
Number of deliveries home birth (Planned & Unscheduled)	Maternity Delivery Details Report	Indicator is for information only	Number of deliveries recorded as being at "Home", planned and unplanned
Mothers who were current smokers at time of booking (SATOB)	Maternity Smoking & Drinking Details Report	Indicator is for information only	Total number of mothers who were recorded as being smokers at their pregnancy booking appointment.
Mothers who were current smokers at time of delivery (SATOD)	Maternity Smoking & Drinking Details Report	Indicator is for information only	Total number of mothers who were recorded as being smokers on their delivery date.
Number of Mothers who were consuming alcohol at time of booking	Maternity Smoking & Drinking Details Report	Indicator is for information only	Total number of mothers who were recorded as consuming alcohol at their pregnancy booking appointment.
Number of Mothers who were consuming alcohol at time of delivery	Maternity Smoking & Drinking Details Report	Indicator is for information only	Total number of mothers who were recorded as consuming alcohol on their delivery date.
Breastfeeding Initiation rates	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT1A) & Maxims Maternity Report (MT001))	Not Applicable	Number of babies whose first feed is from the mother's breast

Maternity - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Transfer of Mothers from Inpatients to Overseas	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005))	Indicator is for information only	Number of transfers of mothers out of Maternity inpatient wards to an off-island Healthcare facility.
Number of births in the High dependency room / isolation room	Maxims Deliveries Report (MT005)	Not Applicable	Number of births which took place in the High Dependancy Room / Isolation Room
Number of PPH Greater Than 1500mls	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Number of deliveries that resulted in a blood loss of over 1500ml
Number of 3rd & 4th degree tears – all births	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Not Applicable	Number of women who gave birth and sustained a 3rd or 4th degree perineal tear
% of babies experiencing shoulder dystocia during delivery	Hospital Electronic Patient Record (TrakCare Maternity Reports (MAT23A & MAT1A) & Maxims Maternity Reports (MT005 & MT001))	Not Applicable	Total number of babies experiencing shoulder dystocia during delivery divided by the total number of births
% Stillbirths Greater Than 24 Weeks Gestation	Hospital Electronic Patient Record (Maxims Maternity Report (MT001))	Not Applicable	Number of stillbirths (A death occurring before or during birth once a pregnancy has reached 24 weeks gestation)
Neonatal Deaths at Less Than 28 days old	Hospital Electronic Patient Record (Maxims Demographics Report (MP001DM) & Maxims Maternity Report (MT001))	Indicator is for information only	Number of deaths during the first 28 completed days of life
Number of babies that have APGAR score below 7 at 5 mins	Hospital Electronic Patient Record (TrakCare Maternity Reports (MAT23A & MAT1A) & Maxims Maternity Reports (MT005 & MT001))	Indicator is for information only	Number of live births (only looking at singleton babies with a gestational length at birth between 259 and 315 days) that have APGAR score (a measure of the physical condition of a newborn baby) below 7 at 5 minutes after birth
% live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Percentage of live births with a gestational age lower than the 3rd centile (3% of babies born at same gestational age will have a lower birth weight than them) delivered after 37 weeks and 6 days of pregnancy.
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005))	Not Applicable	Number of births requiring admission to the Jersey Neonatal Unit at or above 37 weeks gestation
Transfer of Neonates from JNU	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005))	Indicator is for information only	Number of transfers of babies out of the Jersey Neonatal Unit to an off-island Neonatal facility.
Preterm Births ≤27 Weeks (Live & Stillbirths)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Live babies born who were born at or before 27 weeks
Preterm Births ≤36+6 Weeks (Live & Stillbirths)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Live babies born who were born before 37 weeks (less than or equal to 36+6 gestation)
Neonatal Readmissions at Less Than 28 days old	Hospital Electronic Patient Record (Maxims Discharges Report (IP013DM) & Maxims Maternity Report (MT001))	Indicator is for information only	Number of babies that were readmitted to Hospital within 28 days of their delivery date

Mental Health

Section Owner

Director Adult Mental Health & Social Care

Performance Narrative

Access to mental health services remains good, with 98% of people being seen for assessment by Jersey Talking Therapies (JTT) well within the target period (90 days), 94% of people in crisis being seen within 4 hours and 92% of all routine referrals assessed within 10 working days. Waiting lists for memory assessment and autism assessment continue to drop. Waits for psychological treatment and ADHD assessment remain the key challenges for mental health services.

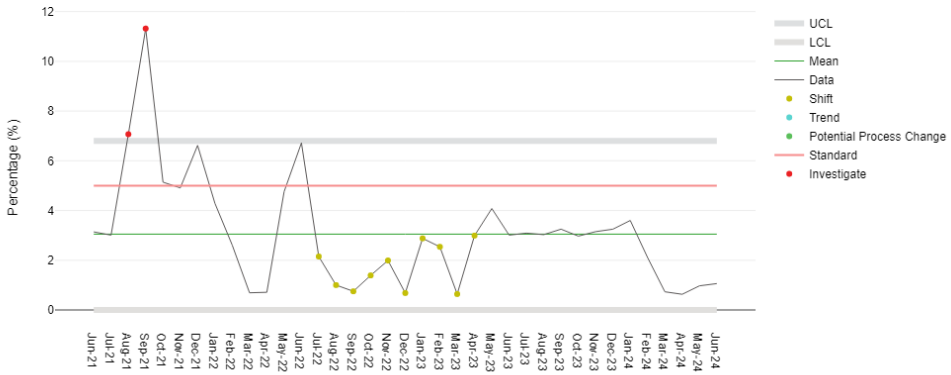
Escalations

The ADHD waiting list is in the process of being reviewed and we have introduced an additional self screening assessment to help speed up the assessment process. JTT have 2 new staff starting shortly, which we hope will alleviate the waiting time for treatement ; in addition a new model of psychological group interventions is being developed across mental health services.

Mental Health - SPC Charts

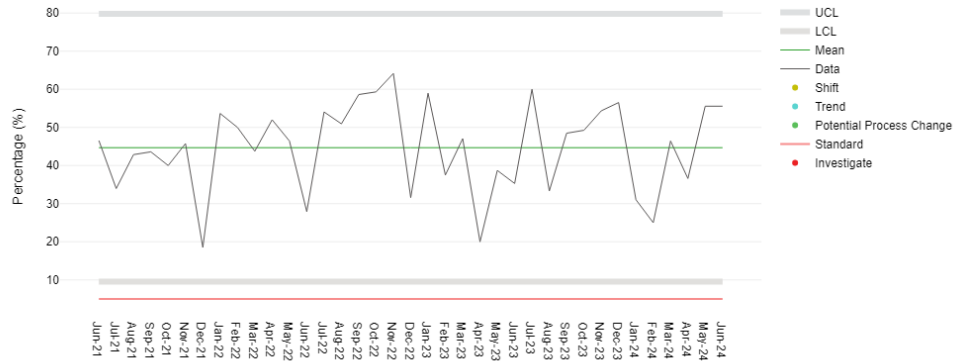
Latest value	Mean
1.1 %	3.1 %

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



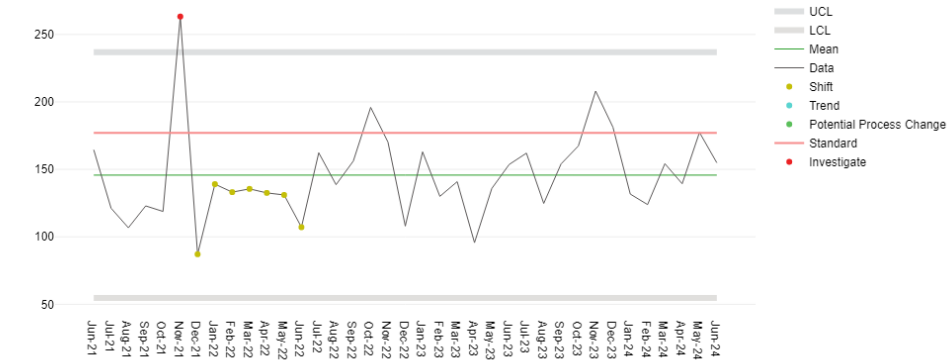
Latest value	Mean
55.6 %	44.7 %

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



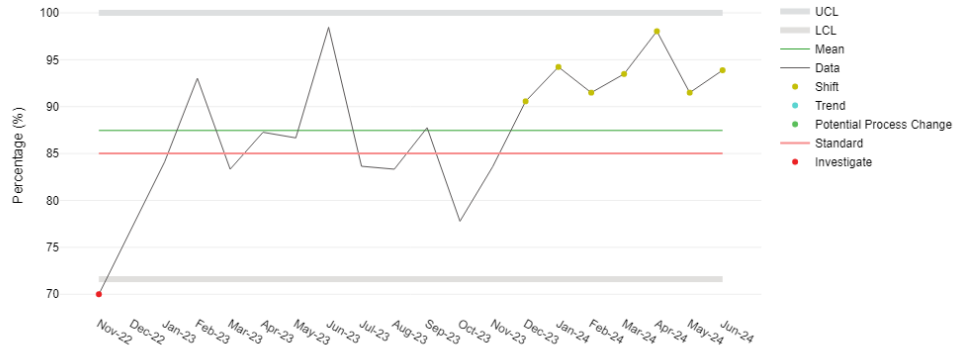
Latest value	Mean
154.89	145.73

JTT Average waiting time to treatment (Days)



Latest value	Mean
93.9 %	87.5 %

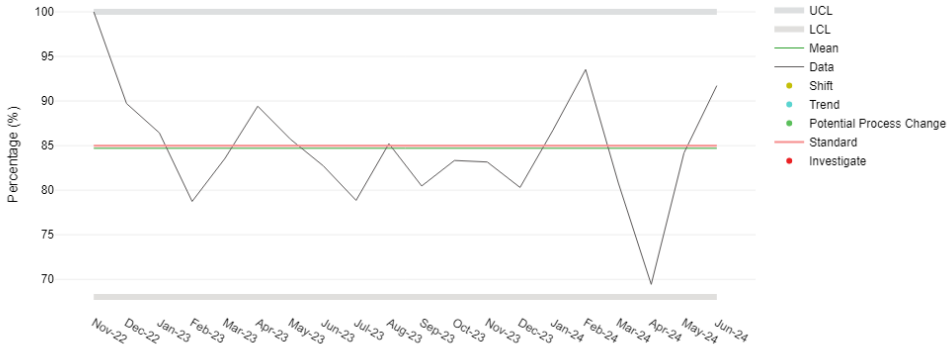
% of referrals to Mental Health Crisis Team assessed in period within 4 hours



Mental Health - SPC Charts

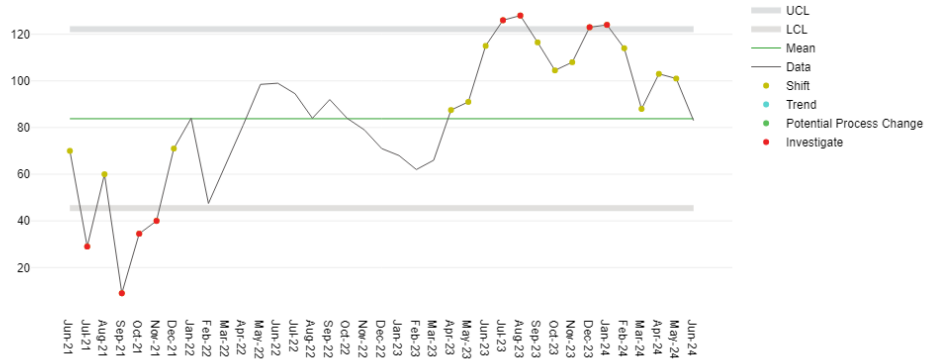
Latest value	Mean
91.7 %	84.7 %

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



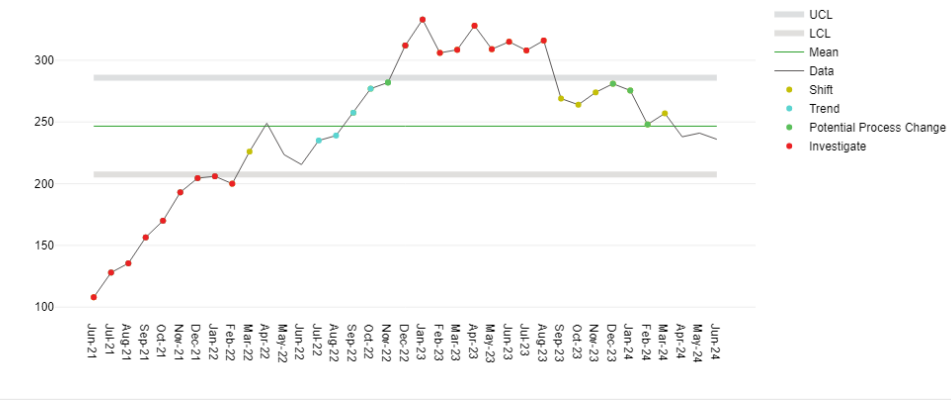
Latest value	Mean
83	83.8

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



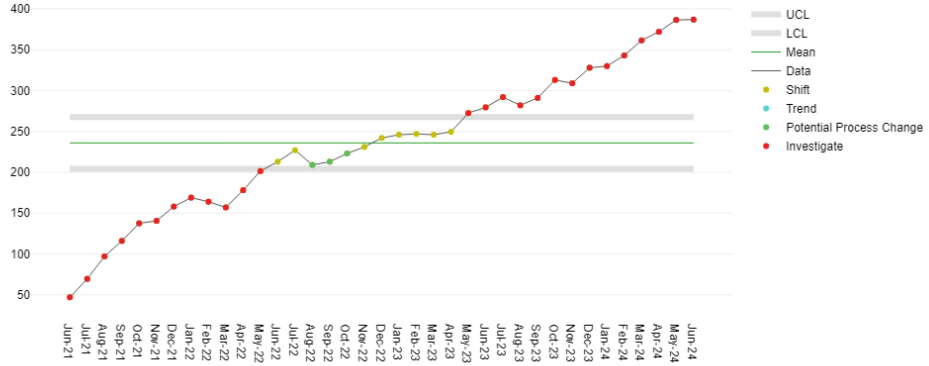
Latest value	Mean
236	246.62

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



Latest value	Mean
387	235.91

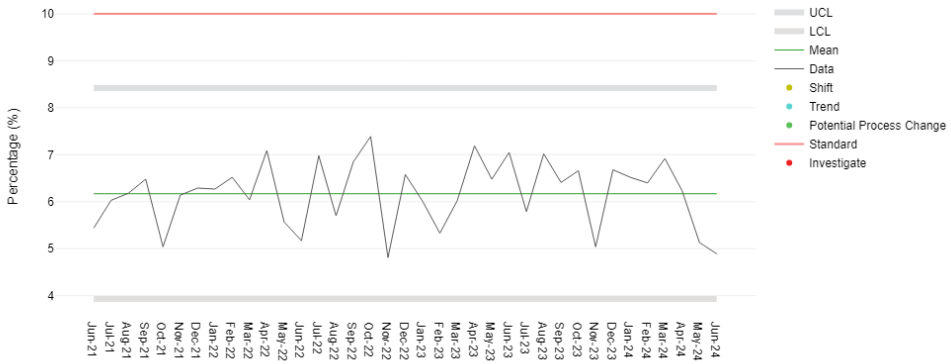
Median wait of clients currently waiting for ADHD Assessment (Days)



Mental Health - SPC Charts

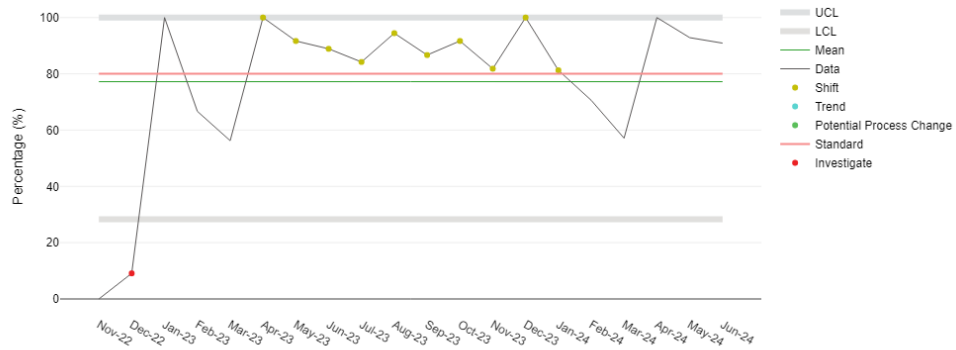
Latest value	Mean
4.9 %	6.2 %

Community Mental Health Team Did Not Attend (DNA) rate



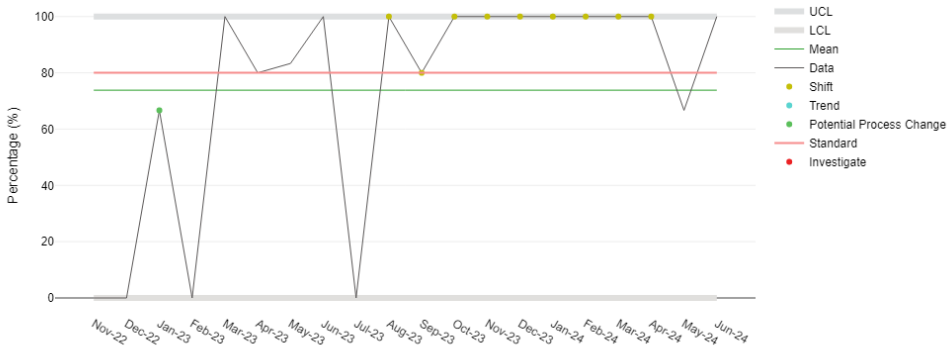
Latest value	Mean
90.9 %	77.2 %

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



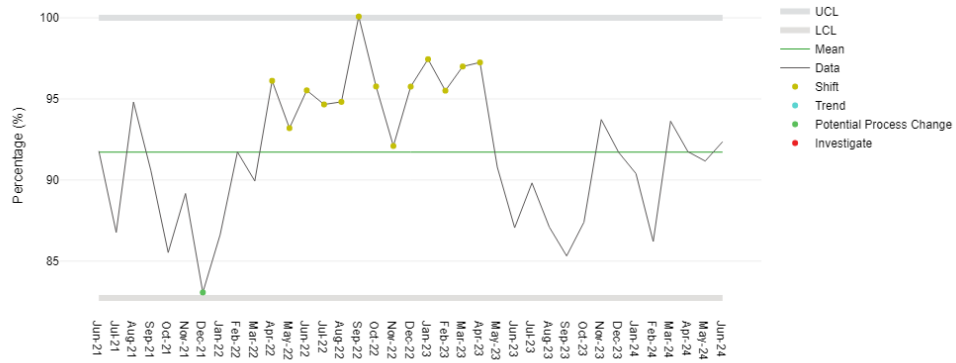
Latest value	Mean
100 %	73.8 %

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



Latest value	Mean
92.4 %	91.7 %

Mental Health Unit Bed occupancy at midnight (Adult and Older Adult Units)



Mental Health - Indicator & Standard Definitions

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

Mental Health - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Median wait of clients currently waiting for Autism Assessment (Days)	Community services electronic client record system	Not Applicable	Autism Assessment Median Waiting times from date of referral to last day of reporting period
Median wait of clients currently waiting for ADHD Assessment (Days)	Community services electronic client record system	Not Applicable	ADHD Assessment Median Waiting times from date of referral to last day of reporting period
Community Mental Health Team Did Not Attend (DNA) rate	Community services electronic client record system	Standard based on historic performance	Rate of Community Mental Health Team (CMHT) outpatient appointments not attended. Numerator: Number of Community Mental Health Team (CMHT, including Adult & Older Adult services) public outpatient appointments where the patient did not attend. Denominator: Total number of Community Mental Health Team (CMHT, including Adult & Older Adult services) appointments booked
% of Adult Acute discharges with a face to face contact from an appropriate Mental Health professional within 3 days	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Admissions Report (ATD5L), Maxims Discharges Report (IP013DM), Maxims Admissions Report (IP013DM) & Community services electronic client record) system	National standard evidenced from Royal College of Psychiatrists	Number of patients discharged from Mental Health Inpatient Unit with an Adult Mental Health Specialty' with a Face-to-Face contact from Community Mental Health Team (CMHT, including Adult & Older Adult services) or Home Treatment within 72 hours divided by the total number of discharges from 'Mental Health Inpatient Unit with an Adult Menatl Health Specialty'
% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Admissions Report (ATD5L), Maxims Discharges Report (IP013DM), Maxims Admissions Report (IP013DM) & Community services electronic client record) system	National standard evidenced from Royal College of Psychiatrists	Number of patients discharged from an 'Older Adult' unit with a Face-to-Face contact from Older Adult Community Mental Health Team (OACMHT) or Home Treatment within 72 hours divided by the total number of discharges from 'Older Adult' units
Mental Health Unit Bed occupancy at midnight (Adult and Older Adult Units)	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP027DM))	Not Applicable	Percentage of Mental Health inpatient beds occupied at the midnight census. Numerator: Number of beds occupied by a patient at midnight in the period, including patients on leave where the bed is retained on Maxims. Denominator: Number of beds either occupied or marked as available for a patient at the midnight census.

Social Care

Section Owner

Director Adult Mental Health & Social Care

Performance Narrative

It is pleasing to see the Number of assessments completed and authorised continuing to perform strongly (92% against an 80% target), especially given the current pressures in adult social care.

The reduction in Learning Disability health checks completed (to 78%, below the 80% target) is attributable to staff leave across the summer months; this will be reviewed by the service with a view to reinstating the previous levels of achievement.

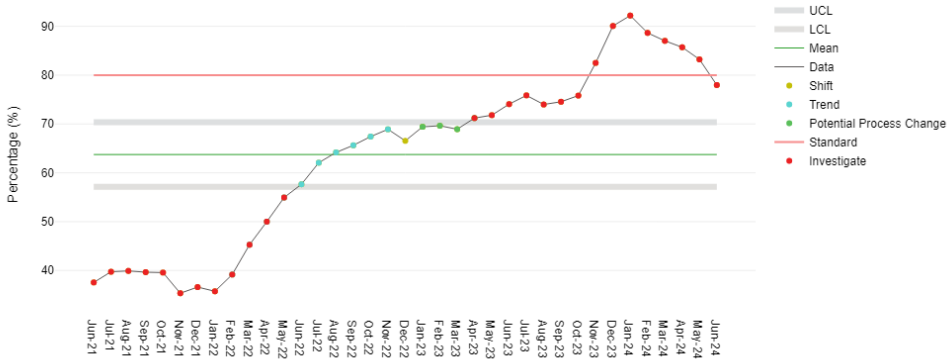
Escalations

There are no escalations arising from these issues.

Social Care - SPC Charts

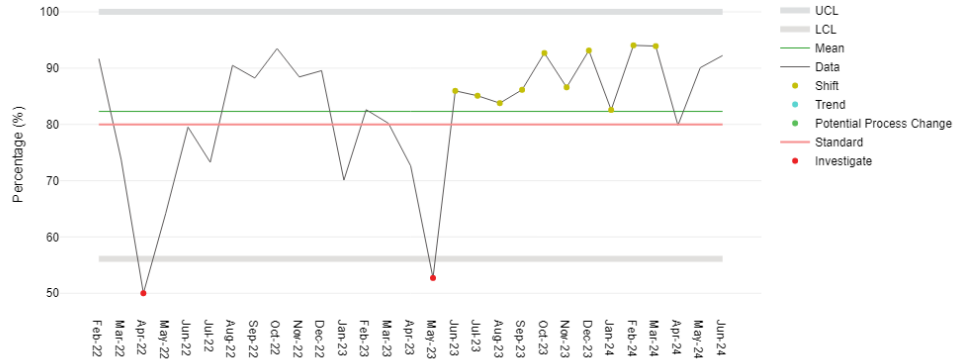
Latest value	Mean
78 %	63.7 %

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



Latest value	Mean
92.2 %	82.3 %

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



Social Care - Indicator & Standard Definitions

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

Quality & Safety

Section Owner

Medical Director / Chief Nurse

Performance Narrative

Complaints/Compliments/PALs

In June 2024, 15 new complaints were received across all care groups, marking a 66.6% decrease from the 45 complaints in June 2023. The team is actively encouraging the use of de-escalation processes on wards and resolving issues at the point of contact to prevent escalation to formal complaints. During the same month, 96 compliments were logged on the Datix system, a 50% increase from June 2023's 64 compliments. Efforts are being made to ensure that patient and relative compliments are recorded and recognized. Additionally, the Patient Advice and Liaison Service (PALS) was relaunched in June 2024 with a media campaign, resulting in an increase in interactions from 27 in June 2023 to 87 in June 2024.

Tissue Viability

There has been one deep tissue injury, where the patient is actively managed by the Tissue Viability Team. Despite having the capacity to understand, the patient has chosen not to adhere to medical advice and is fully aware of the associated risks.

We continue to see effective early identification and reporting of pressure damage. Educational sessions on the prevention and treatment of pressure damage remain well attended.

Infection Prevention & Control Update

Healthcare associated Infections:

There has been one C. difficile infection identified in the hospital in June and this is currently under review as there are potential links with two previous cases on the same ward. Enhanced infection prevention and control measures have been implemented and root cause analysis investigations are underway.

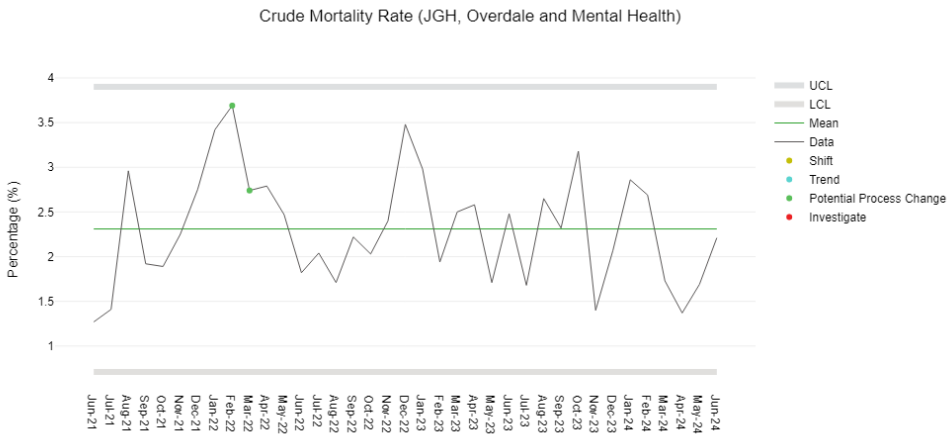
There have been no MRSA bacteraemia’s and the incidence of MSSA bacteraemia has remained low with one klebsiella bacteraemia identified linked to a Hickmann line.

Escalations

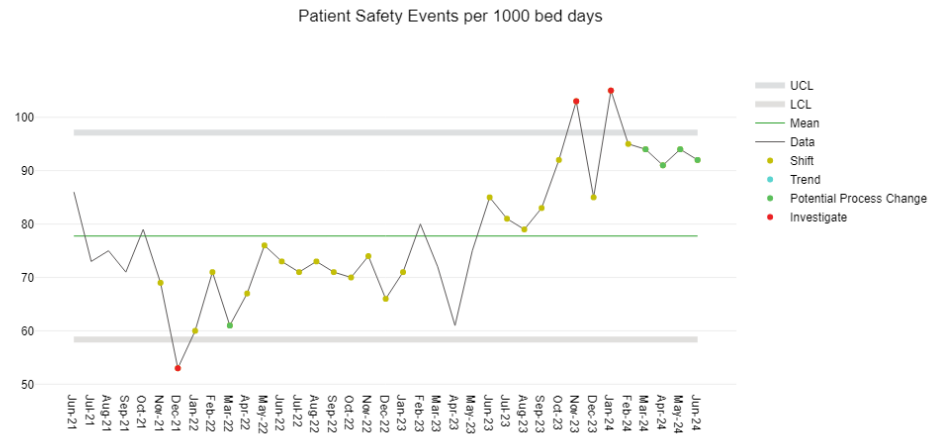
No Escalations

Quality & Safety - SPC Charts

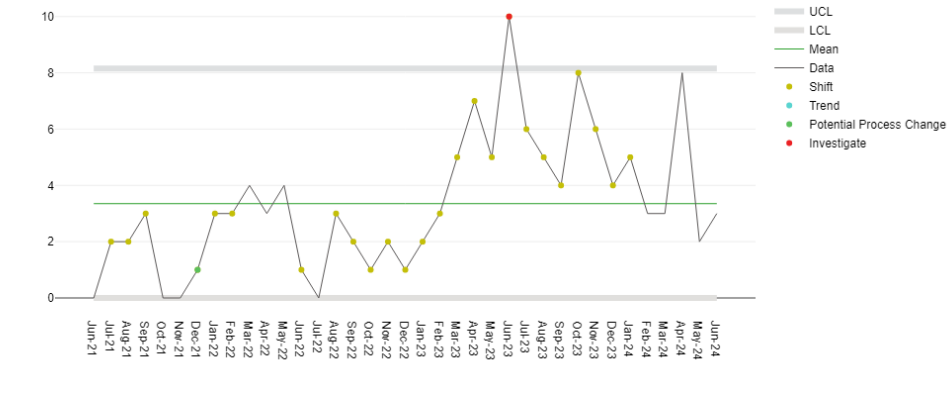
Latest value	Mean
2.2 %	2.3 %



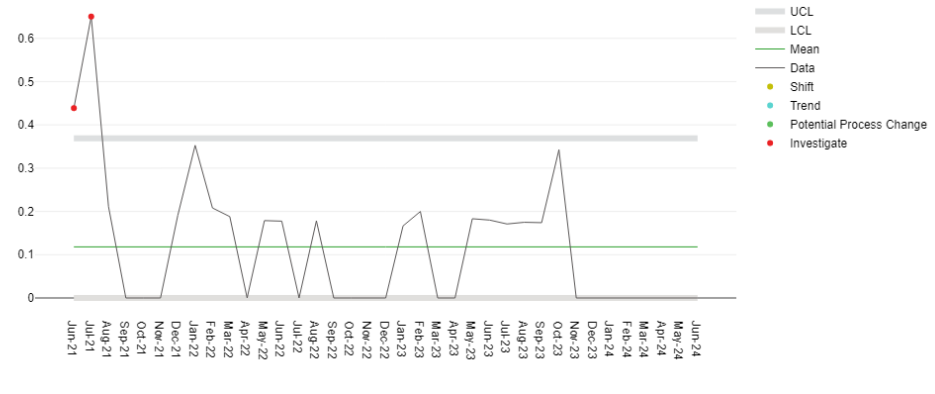
Latest value	Mean
92	77.76



Latest value	Mean
3	3.35



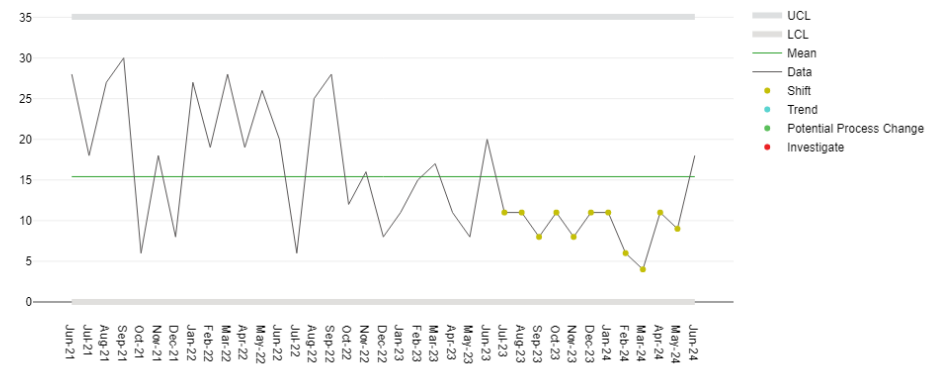
Latest value	Mean
0	0.12



Quality & Safety - SPC Charts

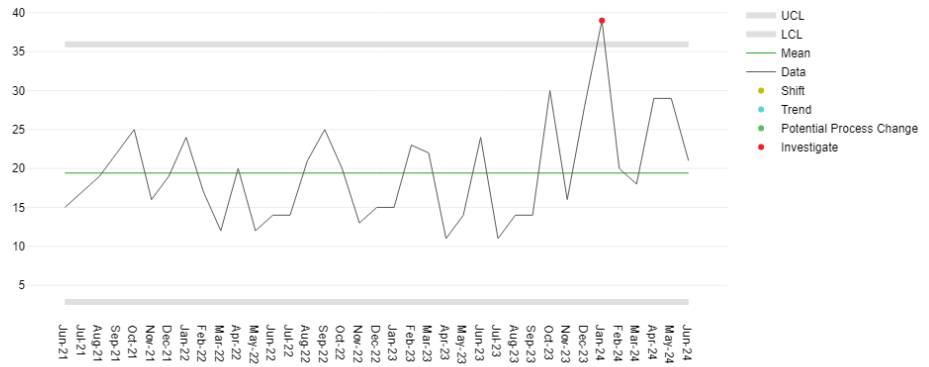
Latest value	Mean
18	15.41

Patient safety incidents with moderate/severe harm/death



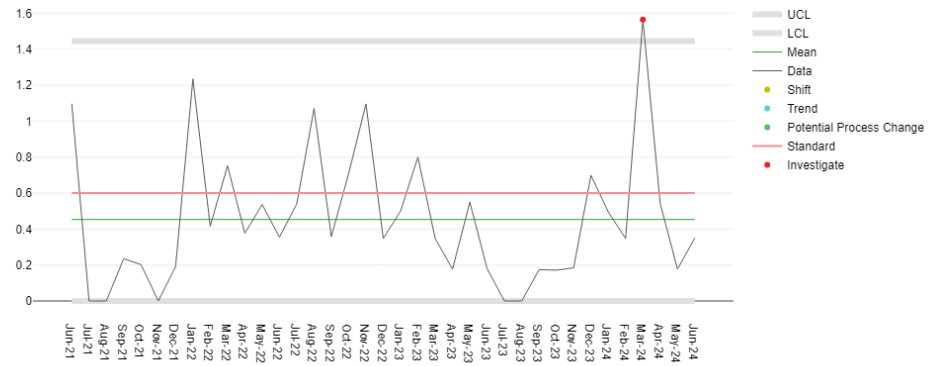
Latest value	Mean
21	19.41

Number of pressure ulcers present upon inpatient admission



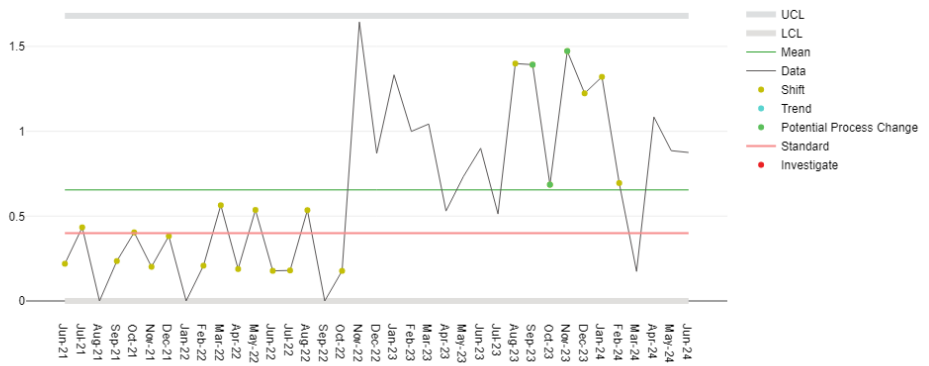
Latest value	Mean
0.35	0.45

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



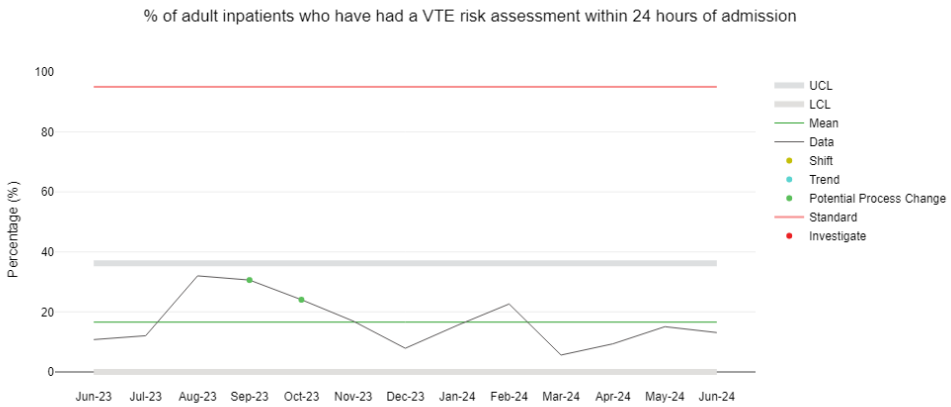
Latest value	Mean
0.87	0.65

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

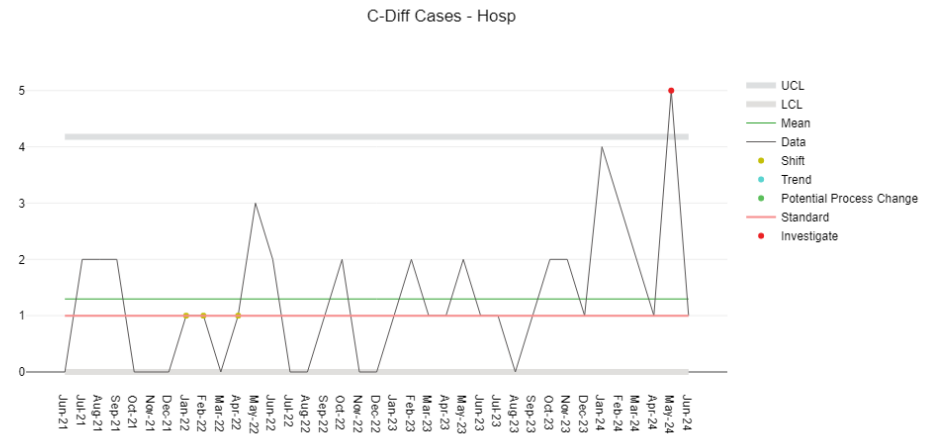


Quality & Safety - SPC Charts

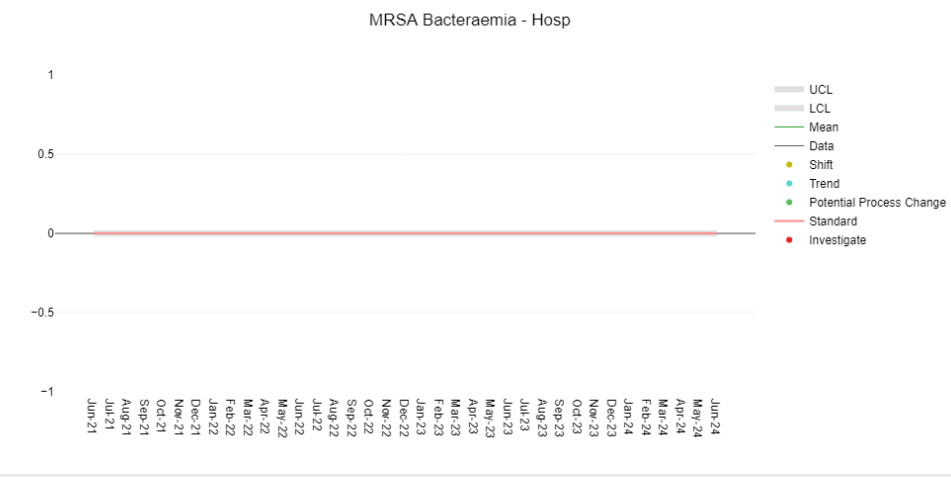
Latest value	Mean
13.1 %	16.6 %



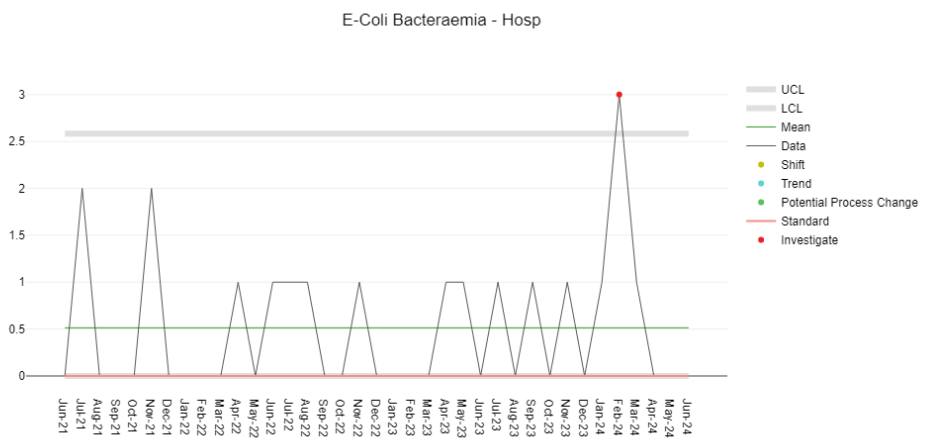
Latest value	Mean
1	1.3



Latest value	Mean
0	0

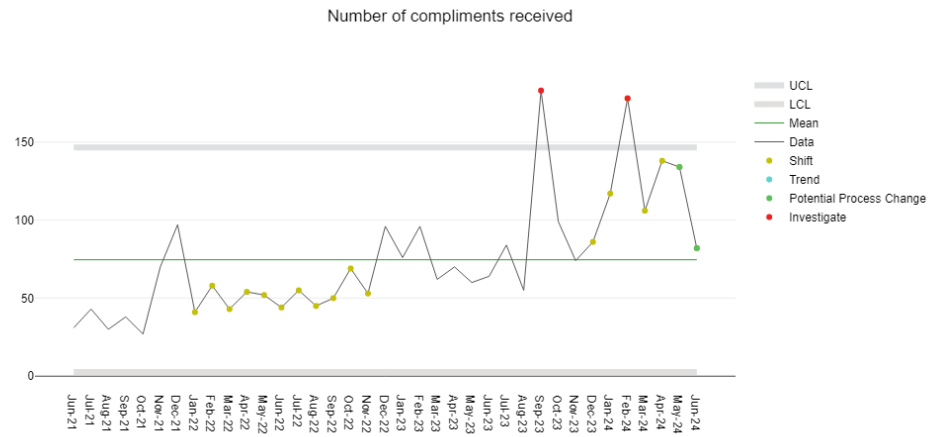


Latest value	Mean
0	0.51



Quality & Safety - SPC Charts

Latest value	Mean
82	74.59



Latest value	Mean
13	30.57

Quality & Safety - Indicator & Standard Definitions

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

Quality & Safety - Indicator & Standard Definitions

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

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Dermatology Sustainability – Initial Discussion**		
Date of Meeting:	25th July 2024	**Agenda Item:**	**18**

Executive Lead:	Claire Thompson, Chief Operating Officer, Acute Services
Report Author:	Dr Simon Chapman, Chief of Service – Surgical Services Emily Hoban, Head of Access

Purpose of Report:	Approval ☐	Assurance ☐	Information x	Discussion ☐
	This paper provides the board with an initial review of the opportunities within the HCS dermatology provision for public patients to support increased capacity and reducing waiting times.			
Summary of Key Messages:	The key messages arising from this report are: Development of a dermatology strategy for Jersey which may incorporate: • A proposed collaboration between primary and secondary care enabling patients to be treated away from the hospital environment for conditions which do not require an acute setting. • Development of clear and defined clinical referral pathways. • Alternative referral options. • Increased skilled workforce to support a range of dermatological conditions. • Development of a hub and spoke model of care. Strategy and business case development to commence once the new substantive consultant starts in post.			
Recommendations:	The Board is asked to support the proposal for the development of a strategy to ensure long term sustainability of dermatology provision for the publicly funded patients on the Island of Jersey.			

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

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Senior Leadership Team	**11 July 2024**	**Continue strategy development**

List of Appendices:
Nil

This briefing paper provides a proposed structure for dermatology to develop a sustainable model to deliver public dermatology services for the residents of Jersey. The brief paper is a starting point for which the new dermatology consultant and the existing dermatology lead can work alongside community and acute colleagues to design a service which is sustainable in the long term.

Dermatology provision across Western Europe has been fragile for many years due to factors such as an aging population, increase in skin cancer due to limited knowledge of prevention factors 30 years ago and the lack of dermatology medical training. The impact of this for Jersey has meant HCS operating a service with a single-handed consultant and limited medical and nursing support resulting in lengthy waiting lists. Moving forward, things are starting to change with the recruitment of a second consultant, implementation of an associate specialist, recruitment of two GPs with a special interest in dermatology, a cancer nurse specialist and a clinical nurse manager.

Improvement in staffing levels is only the start of the move towards a sustainable dermatology service. A dermatology strategy will be developed for the Island once the new consultant commences in post which will consider the following:

- A proposed collaboration between primary and secondary care enabling patients to be treated away from the hospital environment for conditions which do not require an acute setting.
- Development of clear and defined clinical referral pathways.
- Alternative referral options.
- Increased skilled workforce to support a range of dermatological conditions.
- Development of a hub and spoke model of care.

It is proposed that the current clinical lead, the new consultant and the Chief of Service will review the current arrangements, engage with stakeholders across health, primary care, patients and government to develop the strategy for Jersey by the end of Q2 2025.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Finance Report – Month 6**		
Date of Meeting:	25 July 2024	**Agenda Item:**	**19**

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

Purpose of Report:	Approval ☐	Assurance √	Information √	Discussion ☐
	This purpose of this report is, • To provide the Board with an update on the Month 6 Financial position for 2024 and future funding. • To discuss the financial position noting the risks and mitigations and recommendations for future funding.			
Summary of Key Messages:	The key messages arising from this report are: • FY24 YTD M6 deficit is £13.9m giving a headline monthly run-rate of £2.3m. Adjusting for one-off items and non-recurrent costs the underlying monthly run-rate is £2.1m. • FRP savings of £3.6m have been delivered vs £4m plan at M6 made-up of £2m savings from original FRP schemes and £1.6m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures. • The year-end forecast is £24.2m deficit after delivering £5m of FRP savings, with further downside risks from cost pressures that may materialise during the year, before additional mitigation actions are taken. • Recovery actions being taken include: • **Intensive recovery support** working with the Care Groups that have been placed under financial escalation with weekly Executive review and accountability meetings, to reduce the current overspend run-rate and continue delivery of FRP savings • **Further Cost Reduction Actions** - Due to the M6 deterioration in the financial position, urgent additional cost reductions and service reduction options are required in-year to remain within the mandated £24m in-year deficit budget. • **Sustainable long-term funding** - a paper has been submitted to Treasury and the MHSS for discussion at a forthcoming COM (Council of Ministers) meeting, making the case for additional funding to balance the position at year-end and to provide a long-term sustainable funding settlement for HCS.			

Recommendations:	**The Board is asked to note this report.**

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

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
HCS Senior Leadership Team meeting	11 July 2024	Noted and discussed

List of Appendices:
Nil

Executive Summary

FY24 Month 6 Finance Position

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
HCS Categorisation	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)	% Variance	% Variance
Staff Costs	19,419	19,264	110,829	112,876	(2,047)	225,342	231,440	(6,098)	(1.8%)	(2.7%)
Non Pay	9,166	11,920	53,920	65,148	(11,228)	107,700	124,547	(16,848)	(20.8%)	(15.6%)
Income	(2,419)	(1,005)	(12,922)	(12,330)	(592)	(28,491)	(27,199)	(1,292)	(4.6%)	(4.5%)
Grand Total	26,166	30,180	151,826	165,694	(13,867)	304,551	328,788	(24,238)	(9.1%)	(8.0%)

- The Financial position for YTD Month 6 is an £13.9m deficit vs budget giving a headline monthly run-rate of £2.3m. The in-month deficit is £4m against budget which is a deterioration compared to last month.

Underlying position and Run-rate

- Adjusting for one-off items and non-recurrent costs the underlying run-rate is £2.1m.

FRP savings delivery

FRP savings delivery is £3.6m (vs £4m plan) made-up as £2m against original schemes and an additional £1.6m of mitigation schemes to recover slippage and cost pressures. Mitigating actions to recover the position continue to be taken. However, due to the M6 deterioration in the financial position, additional urgent cost reduction actions are being finalised to remain within the mandated £24m deficit budget constraint.

The FRP Programme is in its first year of implementation and has delivered efficiency savings of £3.2m in FY23 (vs target £3m) and has been re-profiled to deliver £5m in FY24, £8m in FY25 and £9m in FY26.

FY24 year-end forecast

- The year-end forecast is £24.2m deficit after delivering £5m FRP savings, with further downside risks from cost pressures, before additional cost reduction actions are taken.

  As reported previously, the key factors driving the forecast deficit are:

  - Exceptional one-off costs in-year £3.8m
  - FRP savings slippage £6m due to delays in enabling support being in place. This is a timing delay, and the savings are expected to be delivered in FY25 and FY26.
  - Estates and equipment £1.2m
  - Tertiary care contracts activity and price increases £2m
  - Activity increases (above baseline budget) in high cost-low volume (HCLV) services and treatments £6.4m
  - Drugs and other non-pay inflation in excess of budget funding £2.4m
  - Loss of WLI funding £2.2m
  - Additional costs of implementing clinical/medical model following recommendations of Royal College reviews into Medicine and Maternity Services.

Recovery Actions

- The following recovery actions are being taken:

  - **Intensive recovery** support working with the Care Groups that have been placed under financial escalation with weekly Executive review and accountability meetings, to reduce the current overspend run-rate and continue delivery of FRP savings
  - **Further Cost Reduction Actions** - Due to the M6 deterioration in the financial position additional urgent cost reductions and service reduction options are under discussion to remain within the mandated £24m deficit budget.
  - **Sustainable long-term funding** – a paper has been submitted to Treasury and the MHSS for discussion at a forthcoming COM (Council of Ministers) meeting, which has been shared with the Advisory Board, making the case for additional funding to balance the position at year-end and to provide a long-term sustainable funding settlement for HCS.

The key points and recommendations of the paper are as follows:

In a nutshell

- HealthCare requires a mature long-term funding settlement to make it financially sustainable and provide stability with budget resilience by building contingency reserves to absorb normal operational variations.
- Sustainable Health is not only about the efficient running of Health and Care Services, but about joining-up an inter-dependent Health and Care System that can respond to ever increasing demographic and political demands and rising public expectations by delivering better quality of care, more efficiently and with the right infrastructure support, that makes it affordable and financially sustainable.

GoJ/COM and Healthcare leaders are at a crossroad and face two options to tackle Health and Care funding that is sustainable into the future:

1. Continue 'As Is' and provide yearly bail-out funding, following close scrutiny, to extinguish deficits
2. Agree a long-term funding settlement for Health and Care to address the underlying underfunding driven by demand vs capacity demographics, impact of the JCM model and non-recurrent Covid funding that has led to more services being established permanently that now require recurrent funding to continue.

- Efficiencies alone will not be sufficient. Recognising that FRP efficiency savings reduce the deficit by

limiting the rise in the rate of expenditure, to balance the financial position requires a permanent rise in the level of funding.

- Many of the drivers of the deficit are symptoms caused by capacity gaps in essential support structures and functions including:
    1. HR/Workforce and Procurement,
    2. Off-island Contracting and Commissioning, and
    3. BI Analytics capacity to provide good activity information to allow robust planning and the development of an evidence-based annual Operational Plan as a basis for annual Budget Planning and informed negotiations with GoJ and Treasury.
- HCS needs these support functions to be in place and investment in these is essential for operational stability and to support HCS deliver financial balance.

Achieving Financial Sustainability

- Balancing the financial position requires a permanent rise in the level of funding
- The evidence-based findings and recommendations of three independent pieces of work, Jersey Care Model (JCM), Health Economic Unit (HEU) work on Health Funding Reform and FRP Drivers of the Deficit, commissioned in recent years are consistent in their conclusion, which show a widening exponential gap between expenditure and income that is unsustainable without system integration and considering long-term funding options.
- This is likely to result in additional deficits in future years unless decisions are made to either fund these services permanently or discontinue provision.

Conclusion

- FY24 YTD M6 deficit is £13.9m giving a headline monthly run-rate of £2.3m. Adjusting for one-off items and non-recurrent costs the underlying monthly run-rate is £2.1m.
- FRP savings of £3.6m have been delivered vs £4m plan at M6 made-up of £2m savings from original FRP schemes and £1.6m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.
- The year-end forecast is £24.2m deficit after delivering £5m of FRP savings, with further downside risks from cost pressures that may materialise during the year, before additional mitigation actions are taken.
- Recovery actions being taken include:
    - **Intensive recovery support** working with the Care Groups that have been placed under financial escalation with weekly Executive review and accountability meetings, to reduce the current overspend run-rate and continue delivery of FRP savings
    - **Further Cost Reduction Actions** - Due to the M6 deterioration in the financial position urgent additional cost reductions and service reduction options are under discussion to remain within the mandated £24m deficit in-year.
    - **Sustainable long-term funding** - a paper has been submitted to Treasury and the MHSS for discussion at COM (Council of Ministers) meeting, making the case for additional funding to balance the position at year-end and to provide a long-term sustainable funding settlement for HCS.

Main Report

FY24 Month 6 Finance Position

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
HCS Categorisation	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)	% Variance	% Variance
Staff Costs	19,419	19,264	110,829	112,876	(2,047)	225,342	231,440	(6,098)	(1.8%)	(2.7%)
Non Pay	9,166	11,920	53,920	65,148	(11,228)	107,700	124,547	(16,848)	(20.8%)	(15.6%)
Income	(2,419)	(1,005)	(12,922)	(12,330)	(592)	(28,491)	(27,199)	(1,292)	(4.6%)	(4.5%)
Grand Total	26,166	30,180	151,826	165,694	(13,867)	304,551	328,789	(24,238)	(9.1%)	(8.0%)

- The Financial position for YTD Month 6 is an £13.9m deficit vs budget giving a headline monthly run-rate of £2.3m. The in-month deficit is £4m against budget which is a deterioration compared to last month.

The key drivers are:

Year-to-date (YTD) position is a £13.9m deficit:

- **Staff Costs £2.0m overspend** is made up of an agency overspend of £6.5m (no. of agency staff: 170 (33 doctors and 137 Nurses, AHPs and Other), an overtime overspend of £1.8m, and a budget pressure of £0.8m, offset by a substantive underspend of £7.0m (no. of vacancies: 517 FTE). The underlying factors driving these cost pressures are recruitment issues and dependency on temporary staffing, and a £0.8m year-to-date impact of additional PAs paid following doctors' job planning.

  The Care Groups/Directorates accounting for this Staff Costs overspend are Medical Services £1.6m, Surgical Services £1.1m, Chief Officer's Dept. £0.8m, Women and Children £0.7m, and Mental Health £0.3m. All other areas are underspent on staffing. £0.5m of the Surgical Services overspend relates to doctors' job planning impacts, with £0.2m in Medical Services.

- **Non-Pay £11.2m overspend** includes significant overspends in Medical Services £2.2m in relation to consumables and Oncology and Medical Day Care drugs, Social Care £1.9m mainly in relation to domiciliary care packages, and Surgical Services £1.4m in relation to consumables, Tertiary Care £0.9m in relation to acute hospital referrals to the UK, an overspend of £0.8m in Estates & Hard Facilities Management mainly in relation to utilities and maintenance, £0.6m in Mental Health due to placements, and £0.4m in Non-Clinical Support Services.

  There is also an overspend of £1.7m in Chief Officer's Dept., which includes £0.8m in relation to the opening budget pressure aligned here as part of budget setting for 2024, and a £0.7m cost pressure from the recharge of Accommodation Service income 'voids' for Q1 and 2 2024 (in discussion to resolve).

- **Income under-achievement £0.6m** includes under-achievements in Surgical Services £1.1m, with under-delivery of accommodation income and FRP additional income generation. Social Care and Mental Health income has seen a significant reduction of £0.36m and £0.26m respectively in M6 which is being investigated. Non-Clinical Support Services £0.2m with reduced recovery of income in Catering through the ending of an SLA with CYPES for school meals, and an under-recovery of Laundry income from external customers. These under-achievements are offset by Health Education income received for Apr-23-Mar-24 with a £0.8m overachievement in Medical Director.

- **Underlying position and run-rate** - Adjusting for the non-recurrent one-off items, budget phasing, over-accruals and recharge, the underlying deficit at M6 is £12.5m or an average monthly run-rate of £2.1m.

FRP savings delivery

- FRP savings of £3.6m have been delivered vs £4m plan at M6 made-up of £2m of original schemes and £1.6m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures. These savings will initially be recognised against the Value for Money target for HCS of £3.986m.
- The FRP Programme is in its first year of implementation and has delivered efficiency savings of £3.2m in FY23 (vs target £3m), and plans to deliver £5m in FY24, £8m in FY25 and £9m in FY26.

FRP Delivery and Development Tracker – FY24 Savings Delivery

FRP Savings Plan by Workstream

Workstreams	Projects	Scheme RAG	2023 Saving Delivered	Full Year 2024 Planned Saving	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2024 Forecast Saving	YTD Plan	YTD Actual Saving	YTD Plan vs Actual Saving	Forecast Variance against Plan	Remaining FYE 2025 Planned Saving	Total Saving Forecast
Delivery Tracker																							
					Actual						Forecast												
Clinical Productivity	Theatres Efficiency		-	2,392	-	-	-	-	-	-	-	10	10	160	160	160	500	695	-	-695	-1,892	692	1,192
Workforce	Clinical - Medical		221	1,723	72	88	78	77	56	118	92	92	101	101	101	101	1,077	574	489	-84	-645	791	2,089
	Clinical - AHPs		119	1,489	13	13	13	69	69	69	134	134	134	134	134	134	1,049	422	248	-174	-440	615	1,784
	Clinical - Nursing		-	2,230	-	-	-	-	-	-	21	30	30	30	30	30	171	426	-	-426	-2,059	2,719	4,949
Non-Pay and Procurement	Non-Pay Controls (NPCP)		-	1,099	19	19	74	25	33	17	18	18	18	18	18	18	298	461	187	-274	-801	158	456
	Procurement		585	195	65	65	65	-	-	-	-	-	-	-	-	-	195	195	195	-	-	-	780
	Medicines Management		65	605	18	24	29	31	46	59	69	59	59	59	59	50	564	249	208	-41	-41	164	793
	Other Non-Pay		-	224	9	9	9	11	11	11	27	27	27	27	27	27	224	60	60	0	-	105	329
Income	Other Income Opportunities		163	781	65	68	68	30	28	32	32	32	58	58	58	58	586	495	291	-204	-195	-	748
	Private Patients		242	371	28	30	30	30	30	30	44	44	-	-	-	-	266	278	178	-100	-105	-	508
Care Groups and Non-Clinical Directorate schemes	£3m in 3 months		1,914	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,914
Total schemes currently in delivery			3,309	11,559	290	316	367	304	306	371	487	497	487	637	637	628	5,329	4,004	1,955	-2,049	-6,229	5,394	15,993
Development Tracker																							
											Planned												
Clinical Productivity	Patient Flow and Discharge/LOS			38							-	-	-	-	-	-	-				-38	27	27
Workforce	Clinical - Nursing			-							-	-	-	-	-	-	-				-	-	-
	Clinical - Medical			72							-	-	-	-	-	-	-				-72	216	216
	Non-Clinical/ Directorate			-							-	-	-	-	-	-	-				-	1,840	1,840
	Workforce Savings			583							-	-	-	-	-	-	-				-583	417	417
Non-Pay and Procurement	Procurement			406							-	-	-	8	8	8	25				-381	829	854
	Other Non-Pay			72							12	12	12	12	12	12	72				-	-	72
	Non-Pay Controls (NPCP)			8							-	-	2	2	2	2	7				-2	12	18
Income	Other Income Opportunities			66							-	-	-	3	3	3	9				-57	1,855	1,864
	Private Patients			432							79	94	94	94	94	94	551				120	1,534	2,085
Mitigating Schemes	Unidentified recurrent effect of 2023 £3m in 3m			963							-32	-32	-32	-32	138	138	147				-816	38	185
	Identified mitigating budget measures			1,269	-	-	953	257	218	174	38	38	38	-	-	-	1,715	-	1,602	446	446	-	1,715
Total Schemes being prepared for delivery				3,909	-	-	953	257	218	174	97	112	114	87	257	257	2,525				-1,829	6,767	7,578
TOTAL FRP SCHEME SAVINGS			3,309	15,467	290	316	1,320	562	524	544	584	609	601	725	894	885	7,854	4,004	3,557	-1,603	-7,612	12,162	25,285

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

FRP Savings FY23-FY25 - At a glance

FRP Project Plans Development Summary

Workstreams	Projects	Total Savings Identified	FY23 Delivered Savings	FY24 Identified Savings	FY25 Identified Savings	Total Risk Adj Amount	RAG Staus
Clinical Productivity	Patient Flow and Discharge/LOS	64	-	38	27	72	
	Theatres Efficiency	3,084	-	2,392	692	3,084	
Workforce	Clinical - Medical	3,023	221	1,795	1,007	2,706	
	Clinical - Nursing	4,949	-	2,230	2,719	4,949	
	Clinical - AHPs	2,224	119	1,489	615	2,254	
	Non-Clinical/ Directorate	1,840	-	-	1,840	460	
	Workforce Savings	1,000	-	583	417	250	
Non-Pay and Procurement	Medicines Management	923	65	642	216	1,727	
	Procurement	2,015	585	601	829	1,089	
	Other Non-Pay	401	-	296	105	347	
	Non-Pay Controls (NPCP)	1,277	-	1,107	170	1,374	
Income	Other Income Opportunities	2,865	163	847	1,855	1,036	
	Private Patients	2,579	242	802	1,534	1,055	
Care Groups and Non-Clinical Directorate schemes	£3m in 3 months	1,914	1,914	-	-	2,404	
Mitigating Schemes	Unidentified recurrent effect of 2023 £3m in 3m	1,001	-	963	38	241	
TOTAL FRP SAVINGS		**29,758**	**3,309**	**14,235**	**12,214**	**23,498**	

FY24 Year-end Forecast

- The year-end forecast is £24.2m deficit after delivering £5m FRP savings, with further downside risks from cost pressures, before additional mitigation actions are taken. As reported previously, the key factors driving the forecast deficit are:
    - Exceptional one-off costs in-year £3.8m
    - FRP savings slippage £6m due to delays in enabling support being in place. This is a timing delay, and the savings are expected to be delivered in FY25 and FY26.
    - Estates and equipment £1.2m
    - Tertiary care contracts activity and price increases £2m
    - Activity increases (above baseline budget) in high cost-low volume (HCLV) services and treatments £6.4m
    - Drugs and other non-pay inflation in excess of budget funding £2.4m
    - Loss of WLI funding £2.2m
    - Additional costs of implementing clinical/medical model following recommendations of Royal College reviews into Medicine and Maternity Services.

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

Staff Costs £6.1m forecast overspend due to a £12.0m overspend on agency locums (total forecast spend £19.2m), and £1.2m from negative budget pressures, partially mitigated by a £7.1m underspend on substantive staffing due to vacancies.

The net impact above is made-up of:

- Net overspends due to agency/locums and substantive costs in Medical Services £3.7m, Surgical Services £2.3m, Women & Children's Services £1.3m, Mental Health £0.5m, and Social Care £0.1m, which are mitigated by substantive pay underspends of £1.9m in other Care Groups.

  The Chief Officer's Dept. adverse variance of £4.7m (Pay £0.7m and Non-pay £4.5m) is due to holding £2.7m of the total £7.5m of opening budget pressures and a £2.8m contingency for additional cost pressures arising during the year.
- £1.2m re the full year impact of doctors' back-pay from job planning.

Non-Pay overspend £16.8m with the main forecast overspends in Chief Officer's Dept. £4.5m, Medical Services £3.9m, Social Care £2.3m, Tertiary Care £1.5m, Surgical Services £1.4m, Estates £1.0m, Medical Director £0.9m, Non-Clinical Support Services £0.5m, Mental Health £0.3m, Improvement & Innovation and Primary Care both £0.2m, and Women & Children £0.1m.

Income under-achievement £1.2m is due to the current forecast shortfall in Surgery private patient income of £1.7m due to reduction in accommodation income and under-delivery of private income generating activity. There is further risk to this position of c.£2m without corrective recovery action to deliver the planned private income generation project supported by Sorel ward which was planned to be ring-fenced. The reduction in M6 income in Social Care and Mental Health of £0.36m and £0.26m respectively is also a significant risk to the forecast. There is also a £0.5m under-achievement in Non-Clinical Support Services, mainly due to delays in delivery of expected additional Laundry income, and the cessation of school meals provision to CYPES.

These pressures are partially offset by non-recurrent over-recovery of Health Education England income in Medical Director £0.8m.

Recovery Actions

The following recovery actions are being taken:

- **Intensive recovery support** working with the Care Groups that have been placed under financial escalation with weekly Executive review and accountability meetings, to reduce the current overspend run-rate and continue delivery of FRP savings
- **Further Cost Reduction Actions -** Due to the M6 deterioration in the financial position additional urgent cost reductions and service reduction options are under discussion to remain within the mandated £24m deficit in-year.
- **Sustainable long-term funding** – a paper has been submitted to Treasury and the MHSS for discussion at COM (Council of Ministers) meeting, making the case for additional funding to balance the position at year-end and to provide a long-term sustainable funding settlement for HCS.

Recommendation

The Board is asked to note:

- FY24 YTD M6 deficit is £13.9m giving a headline monthly run-rate of £2.3m. Adjusting for one-off items and non-recurrent costs the underlying monthly run-rate is £2.1m.
- FRP savings of £3.6m have been delivered vs £4m plan at M6 made-up of £2m savings from original FRP schemes and £1.6m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.
- The year-end forecast is £24.2m deficit after delivering £5m of FRP savings, with further downside risks from cost pressures that may materialise during the year, before additional mitigation actions are taken.
- Recovery actions being taken include:
    - **Intensive recovery support** working with the Care Groups that have been placed under financial escalation with weekly Executive review and accountability meetings, to reduce the current overspend run-rate and continue delivery of FRP savings
    - **Further Cost Reduction Actions** - Due to the M6 deterioration in the financial position, urgent additional cost reductions and service reduction options are required in-year to remain within the mandated £24m in-year deficit budget.
    - **Sustainable long-term funding** - a paper has been submitted to Treasury and the MHSS for discussion at a forthcoming COM (Council of Ministers) meeting, making the case for additional funding to balance the position at year-end and to provide a long-term sustainable funding settlement for HCS.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Proposed Future Workforce Report Structure**		
Date of Meeting:	25 July 2024	**Agenda Item:**	**20**

Executive Lead:	Chris Bown, Chief Officer HCS
Report Author:	Ian Tegerdine, Director of Workforce

Purpose of Report:	Approval ☐	Assurance ☐	Information √	Discussion ☐
	This paper provides the Board with the proposed future workforce report structure.			
Summary of Key Messages:	The key messages arising from this report are: The last Board received incorrect workforce data, this was corrected and reposted on the relevant websites after the meeting. A review of the issue has revealed a number of workforce data management and oversight issues that need addressing in order to ensure that accurate data is presented to the Board, its committees and at all levels of management in the organisation. In addition, the HCS Workforce team have set out a forward plan for workforce for the period to March 2025 and beyond, taking into account the needs of the Financial Recover Plan (FRP), a series of priorities have been identified. These priorities have been developed from meetings with the Executive Leadership Team (ELT) and FRP teams as well as discussions with HR leadership in the GoJ and discussion with HCS workforce team leaders. They have been approved in principle with the HCS Chief Officer and have been approved by the Board's People and Culture Committee. It is proposed that the following five priorities are the focus for the HCS Workforce leadership and team over the next nine to twelve months. **1. Recruitment** – The development of an HCS 'Resourcing' team from existing staff who are in temporary staffing, rostering, medical staff recruitment and GoJ resourcing but allocated to HCS. Process mapping and service improvement measures taken. **2. Workforce Data** - The development of a more comprehensive workforce dashboard, with robust data, to be developed for reporting at all levels within HCS. **3. Medical Staff management** – The roll out of comprehensive job planning, appraisal and rostering for medical staff groups.			

	4. HCS Workforce Strategy - The development of a mid to long term strategy for the workforce of HCS, unusually this will need to be completed in the absence of a Clinical strategy. **5. HCS People Plan** – The development of a people plan, taking into account the work already underway in Culture, Engagement and Wellbeing, describing the Organisational Development strategy and plan for the short to mid-term. During this period, it may be necessary to suspend existing Workforce reporting for the July Board meeting and associated People and Culture Committee meetings to enable the data work to progress. It is proposed that the revised workforce data reports and reports on progress against the five priorities form part of the agenda of the future People and Culture Committee. **Finance / workforce implications.** Reduction in the Boards oversight of the workforce during this period. **Risk and issues.** Reduction in medium term of the risk of inaccurate data being fed into the organisation
Recommendations:	The Board is asked to endorse the five workforce priorities for the next 9 to 12 months and note the need to suspend Board reporting of workforce data for the July Board. It is recommended that the Board endorse the ambition to meet the outline structure of workforce reporting for future Boards and committees.

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

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
HCS Senior Leadership Team	11 July 2024	Proposal supported

List of Appendices:
Nil

Health and Community Services - Advisory Board

Proposed Future Workforce Report Structure

(July 2024)

Development of the workforce report and metrics

The future metrics that will be presented to the Board, its relevant subcommittees and to the management levels within the organisation will be based on the key lines of enquiry that may be used by the Jersey Care Commission (JCC) and which are already in use by the Care Quality Commission (CQC) in the UK.

It is expected that the report will evolve over the next 12 months, but the next report should have the key workforce metrics for Board and managerial scrutiny / action.

The key lines of enquiry which are pertinent to the workforce area above all other areas are:

Safe Domain

- Training and development especially mandatory and statutory training (MaST), safeguarding training, risk management training.
- Discrimination and harassment protection especially equality, diversity and inclusion (EDI) and protected characteristics
- Recruitment checks
- Disciplinary processes
- Staffing levels and skills mix
- Working hours management
- Bank, locum and agency procedures.
- Raising concerns, speaking up.

Effective Domain

- Training needs assessment
- Staff development and training
- Appraisal and team structures enabling accountability
- Clinical supervision
- Revalidation
- Performance management
- Team performance
- Staff Mental capacity, deprivation of liberty and Childrens rights legislation and application understanding
- Physical restraint training

Caring Domain

- Raising concerns about disrespect, discrimination, and abuse.
- Promoting a caring and compassionate culture

Responsive Domain

- Understanding needs of people with protected characteristics
- Complaints, concerns and speaking up

Well Led Domain

- Leadership capacity and capability knowledge, experience, and integrity to deliver high quality care.
- Leadership that is sustainable, compassionate, inclusive, and effective
- Creating a culture of support, respect, and value.
- Creating a people and patient centred approach to collaborative and cooperative care
- Staff engagement (especially EDI)
- Staff views and experiences
- Team performance and staff engagement in review and improvement
- Staff recognition and reward
- Staff engagement in service development (especially EDI)
- Performance management in culture and behaviour management
- Talent management
- Staff development and training
- Staff safety and wellbeing
- Promoting equality and diversity
- Staff employment checks, fit and proper person at employment and ongoing.
- Leadership accessibility and visibility
- People Plan (Workforce Strategy and Plan, Organisational Development Strategy, and plan) provides vision and strategy to deliver high quality sustainable care to people and robust plans to deliver.
- Internal communications including quality, sustainability, performance and improvement.
- Ensuring appropriate and accurate information is being processed, challenged, and acted upon.

Hence the report key performance indicators (KPIs) will be shaped by the JCC domains as follows:

Proposed Workforce KPIs:

***SAFE* - Workforce budget - split by care group and profession / grade**

- Staff in post (headcount and whole time equivalent (WTE) by profession and grade – ambition to measure against workforce plans
- Staff Budget
  - Overtime
  - Bank
  - Agency
  - Contingent staffing utilisation rate
  - Contingent staff fill rate

***SAFE* - Staffing Numbers**

- Rostering performance metrics
- Starters
- Leavers
- Vacancy rate (Target 5%?)
- Turnover rate voluntary versus forced (Target <10%?)

- Stability index (Target 80%)
- Working Hours
- Registration checks performance

***SAFE* - Recruitment Performance**

- Line manager time from resignation received to request to recruit
- Request to recruit to advert placed
- Candidates awaiting offer/ clearances / start date
- Time to Hire (Advert to Offer) (Target 8 weeks)
- Time to hire (Advert to start date) (Target TBC)

***WELL LED / RESPONSIVE / CARING* - Staff Engagement and Speaking up**

- Workforce related Datix (Trends/ themes)
- Freedom To Speak Up Guardian (FTSUG) reports (Trends/ Themes)
- Staff survey performance (Local and HCS wide)
- Exit Interview themes.
- Recognition and reward activity
- Internal communications activity

***SAFE* - Absence**

- Sickness absence (Target <4.5%)
- Long term sickness (Target <2%)
- Numbers on maternity and adoption leave
- Annual leave taken (% taken by quarter)

***WELL LED / RESPONSIVE* - Equality and Diversity**

- EDI profile (narrative and target)
- Relative likelihood of white individual appointed to role compared with BAME (Target 1)
- Relative likelihood of BAME individual entering disciplinary or grievance compared with BAME (Target 1)
- Participation in training and development BAME compared with Non BAME staff.
- % staff declaring disability including LD
- % staff declaring LGBTQI+ status
- % staff female / male / not declared
- Age profile
- Gender pay gap
- EDI pay gap

***WELL LED / EFFECTIVE* - Training and Development**

- Training needs assessment
- MaST compliance (Target 85%)
- MaST classroom did not attend (DNA) rates Target <5%)
- Induction attendance (Target 90%)
    - GoJ
    - HCS
    - Local

- Doctors in training with educational supervisors at 4 weeks after start date (Target TBA)
- Appraisal rate (Target 90%)
- Medical job plan coverage (Target 95%)
- Mid-year review rate (Target 90%)
- Training programme attendance
    - Leadership
    - Non MaST
- Revalidation performance

WELL LED - Employee Relations

- Formal disciplinary (conduct / capability/ other)
- Formal grievance (group / Individual)
- Informal employee relations (ER) cases
- Sickness management
- Performance improvement
- Bullying and harassment
- Employment tribunal

We will seek to set targets and to 'RAG' rate performance against these targets and aspire to show trends against each metric.

We will seek appropriate comparators where possible, especially those in relation to Island communities alongside international comparators in healthcare.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**People and Culture Committee Report**		
Date of Meeting:	25 July 2024	**Agenda Item:**	**21**

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

Purpose of Report:	Approval ☐	Assurance √	Information √	Discussion ☐
	This paper provides assurance to the HCS Advisory Board on the work of the People and Culture Committee and escalate issues as necessary.			
Summary of Key Messages:	The key messages arising from this report are: • The People and Culture Committee met on Wednesday 26 June 2024. The meeting was chaired by Carolyn Downs CB. • The Committee heard the experiences of two staff members regarding the recruitment process which highlighted areas of improvement that are both outside and within the control of HCS. • Additional agenda items included, - Workforce emerging priorities, the action plan following the Law at Work Exit Interview Report, deep dive into recruitment and sickness absence, pharmacy staffing, cultural change, antiracism and freedom to speak up (FTSU).			
Recommendations:	The Board is asked to note the report.			

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

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

List of Appendices:
Nil

MAIN REPORT

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

Staff Story

Two members of staff attended the Committee to share their experience of the recruitment process to enable the Committee to better understand the themes and identify any specific areas that can be supported to improve.

Themes arising include lack of communication (during both the recruitment and onboarding stages) and difficulties with accommodation. The Committee noted that some of these issues are out with the control of HCS as the function is within another Government of Jersey (GOJ) department. However, there are issues, specifically regarding medical recruitment, that HCS can resolve.

A paper has been requested for the Committee meeting in September which describes the actions that HCS can take to resolve some of the issues. In addition, the Committee will write formally to the relevant Director responsible for People Hub and the accommodation service.

Workforce Emerging Priorities

The Director of Workforce shared the priorities agreed with the Chief Officer for the next nine months.

1. Recruitment
2. Workforce data
3. Medical staff management
4. HCS Workforce Strategy
5. HCS People Plan

The Committee agreed with these priorities, and each will feature as a standing item on the Committee agenda.

Law at Work: Exit Interviews

The Committee received a paper providing the headline themes of the review of exit interviews undertaken by 'Law at Work' in November 2023 (previously presented to the HCS Advisory Board during May 2024) and the proposed action plan in response.

Whilst it was acknowledged that there are interventions in place, the committee concluded that there is an absence of formal triangulation of data points to assure the Committee that specific actions are being taken to address issues raised and the impact of these.

The Committee will continue to monitor this alongside the Cultural Change Programme.

Recruitment

The recruitment process was discussed in detail as part of the staff story and the Committee will receive the recruitment action plan at its next meeting in September 2024.

Sickness Absence

The Committee was provided an overview of the work to date on sickness absence management data and benchmarking, and the forward plan that will be developed to provide assurance regarding service delivery and cost savings.

Following the data errors in the last Board report, the Director of Workforce is undertaking a detailed data quality review and report redesign. Consequently, reporting has been suspended until the Board meeting in September 2024.

Pharmacy Staffing

The Committee was provided with the pharmacy workforce position as of June 2024 and the factors that affect recruitment and retention including flexible working, terms and conditions and the renumeration package. Specifically, pharmacists are offered more money to work in GP / Community pharmacy settings in Jersey. In addition, licensing limits flexibility regarding part-time working.

Benchmarking data from similar healthcare jurisdictions shows HCS is in a more favourable position.

Whilst accepting there are issues out with HCS's control, HCS must make things better for pharmacy staff in the organisation.

The Committee has requested a report in six months to understand whether the situation has improved.

Cultural Change Programme

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

The Committee discussed the need to undertake pulse surveys and the triangulation of these results with sickness data, grievances, whistleblowing, turnover, vacancy rate etc. to highlight the areas of concern.

The Committee will continue to monitor the action plan and the impact of this.

Antiracism

The Committee was provided with an update on progress of the action plan developed in response to the results of the survey to understand racism experienced by staff who work within HCS. The Committee understood that this work is starting to make a difference and staff are feeling more comfortable to discuss.

The Committee were advised that the resource available from the People and Corporate Services (PCS) team to support Diversity and Inclusion training is now limited due to restructuring in PCS and the impact of this is being explored.

Whilst there is no legislative framework in Jersey, it was agreed that in principle HCS should be adhering in principle to the Workforce Race Equality Standard (WRES) and the Disability Equality Standard (DES). This is a long-term ambition as HCS does not currently collect this data (across all protected characteristics).

Freedom To Speak Up

The Committee was provided with an overview of FTSU activity from January to June 2024 and were reassured that the increase in activity is a clear indication that employees are showing courage in stepping forward to speak up about their concerns.

Themes identified include breach of confidentiality, bullying / harassment, discrimination (race), other inappropriate attitudes or behaviours, patient safety / quality, worker safety and wellbeing.

The Committee will continue to receive a report from the FTSU Guardian.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Finance and Performance Committee Report**		
Date of Meeting:	25 July 2024	**Agenda Item:**	**21**

Non-Executive Lead:	Julie Garbutt, Chair of the Finance and Performance Committee
Report Author:	Julie Garbutt, Chair of the Finance and Performance Committee

Purpose of Report:	Approval ☐	Assurance √	Information ☐	Discussion ☐
	This paper provides assurance to the HCS Advisory Board on the work of the Finance and Performance Committee and escalate issues as necessary.			
Summary of Key Messages:	The key messages arising from this report are: • The Finance and Performance Committee met on Thursday 27 June 2024. The meeting was chaired by Julie Garbutt. • Agenda items included a review of the terms of reference, performance indicators, financial position, the performance management framework and the board assurance framework.			
Recommendations:	**The Board is asked to note the report.**			

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

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

List of Appendices:
Nil

MAIN REPORT

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

Terms of Reference

The Committee reviewed the terms of reference and some minor amendments have been agreed. Noting the breadth of the agenda, the Committee agreed that additional meetings will need to be scheduled.

Performance Indicators

The Committee reviewed the performance indicators and had detailed discussions regarding elective waiting times (dermatology and clinical genetics), elective theatre utilisation, emergency care, mental health and social care.

The Committee noted the absence of data regarding delayed transfers of care (DTOC) and the Executive team have been asked to consider how this data can be incorporated in the Quality and Performance Report.

Finance Report

The Committee received an overview of the Financial position (month 5), most notably, the year-end forecast deficit has increased to £24.5 million. The Committee discussed the drivers of the deficit, specifically tertiary care contracts and whether commissioning can be done differently.

Recovery actions were discussed which include,

- **Intensive recovery support** working with the Care Groups (Medicine) that have been placed under financial escalation with weekly Executive review and accountability meetings, to reduce the current overspend run-rate and continue delivery of FRP savings.
- **Service reduction options-** a list of options for service reductions has been shared with the Advisory Board and MHSS for consideration to eliminate the forecast deficit. The MHSS has not approved any of the options proposed.
- **Sustainable long-term funding** – a paper has been submitted to Treasury and the MHSS for discussion at a forthcoming COM (Council of Ministers) meeting, which has been shared with the Advisory Board, making the case for additional funding to balance the position at year-end and to provide a long-term sustainable funding settlement for HCS.

Performance Management Framework

The Committee were provided with the draft of the Performance Management Framework which sets out the overarching principles and approach to delivering a high performing organisation.

Following some points of clarification, the Committee agreed that this framework would be presented to the Board in September 2024.

Board Assurance Framework

The Committee reviewed the relevant sections of the Board Assurance Framework (BAF) and agreed,

1. **Operational Performance (Access)**: whilst the committee received assurance regarding the management of urgent patients, the risk refers to all patient (urgent and routine) and on this basis agreed to leave it at 20.

2. **Finance**: Until the £24.5million is approved by the Council of Ministers (COM), the level of risk has increased from 20 to 25. The impact of not receiving this funding will cause all BAF risks to increase

Matters to be Escalated to the Board

The Committee noted that the financial position is a standing item at the Board and therefore does not require additional escalation.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Quality, Safety and Improvement Committee Report**		
Date of Meeting:	25th July 2024	**Agenda Item:**	**21**

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

Purpose of Report:	Approval ☐	Assurance √	Information ☐	Discussion ☐
	This paper provides assurance to the HCS Advisory Board on the work of the Quality, Safety and Improvement Committee and escalate issues as necessary.			
Summary of Key Messages:	The key messages arising from this report are: • The Quality, Safety and Improvement Committee met on Thursday 27 June 2024. The meeting was chaired by Dame Clare Gerada. • Agenda items included patient experience, freedom to speak up, quality indicators, quality issues, harm revie process, serious incidents, improvement plans for rheumatology, acute medicine and maternity, prescribing data, cannabis prescribing and ADHD prescribing.			
Recommendations:	**The Board is asked to note the report and the following escalations.** 1. Central Alert System: no central purchasing area, posing a risk to the management of equipment / consumable alerts. 2. Medical Model (Medicine Improvement Plan): lack of funding for six Consultants to fully implement the medical model. Unable to provide community-based / hospital services such as Care of Elderly. 3. Cannabis prescribing: lack of clinic regulation, prescription of cannabis to people with known mental illness and public health risk due to increased likelihood of those driving under influence of this group of drugs. 4. Improvements noted in Maternity Services and Patient Experience.			

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

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

List of Appendices:
Nil

MAIN REPORT

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

Patient Experience

The Committee received an overview of patient experience activity from 1st Jan 2024 to 31st May 2024. Specifically,

- Complaints have decreased by 48% year-on-year for the same period
- An audit and categorisation of the outcomes of closed complaints, shows that 34% of the complaints received were upheld, and 23% were partially upheld
- Response times continue to improve, with the current rolling three-month average for closing a stage 1 complaint at ten days, compared to 49 days last year.
- Compliments for the same period last year increased by 304, which equates to a rise of 81.7%.

The Committee commended those who facilitated these improvements for the progress made in supporting patients and staff to resolve complaints.

Freedom to Speak Up

The Committee was provided with an overview of FTSU activity from January to June 2024. It was reassured that the increase in activity clearly indicates that employees are showing courage in stepping forward to speak up about their concerns.

Themes identified include breach of confidentiality, bullying/harassment, discrimination (race), other inappropriate attitudes or behaviours, patient safety / quality, worker safety and wellbeing. The Committee was reassured that any significant patient safety issues are reported to the Chief Nurse and Medical Director without delay (issues are identified, not the reporter).

The Committee will continue to receive a report from the FTSU Guardian.

Quality Indicators

The Committee received and reviewed the Quality Indicators for May 2024.

The reduction in pressure trauma over the past 12 months was noted, and the Committee received an overview of the targeted training that underpins these improvements.

The number of falls resulting in moderate or severe harm has reduced and is thought to be a direct result of increased observation of patients within bay areas.

Whilst the overall infection rate has dropped, there have been three reported cases of C. Difficile infection in the hospital with two cases linked to one ward, suggesting potential cross infection. An investigation will be carried out for each to determine the root cause(s) and targeted work has already begun.

Quality Issues

The Committee received an overview of quality issues raised primarily through the Serious Incident Review Panel (SIRP) including the NPSA Alert: Sodium Valproate, VTE Assessment, use of Theatre Checklists and the Central Alert System (CAS).

The Committee was assured that appropriate action plans are in place to address these issues and will receive updates at future meetings.

The Committee agreed that the lack of organizational oversight of equipment and consumable purchase (due to areas being able to purchase their own equipment) must be escalated to the Board as this poses a significant risk for the management of alerts related to equipment / consumables.

Harm Review Process

The Committee were provided with an overview of the current harm review process. In summary,

- HCS continues to improve access. Remain on track to deliver access targets and recovery targets set and agreed by the Senior Leadership Team.
- Deep dive reviews could be undertaken in specific specialities, but as there is oversight at the weekly patient tracking list (PTL) meetings, this is not recommended.

The Committee agreed with the recommendations and any discussions regarding potential deep dives can be continued outside this meeting.

Serious Incidents

The Committee received an overview of the current Serious Incident (SI) position.

The Committee was reassured regarding the management of SIs and the learning; however, the Committee requested to see all the recommendations from the investigations at its next meeting in August 2024.

Rheumatology Improvement Plan

The Committee received an update on the progress of the rheumatology action plan. Of the 32 recommendations, 17 have been signed off and embedded as BAU within the service and 15 are on track for delivery with supporting evidence available and no escalation required.

The Committee will continue to receive progress reports.

Medicine Improvement Plan

The Committee received an update on the progress of the medicine improvement plan. Whilst only 1 out of 67 recommendations have been identified as complete, recommendations are only signed off once consistent progress is assured. 30, 60, and 90-day reviews have been introduced to ensure that learning is embedded as business as usual. Dedicated project management support has been introduced in the last couple of weeks, and the external physician advisor's support continues. Anticipating an improvement in the number of complete recommendations over the next four weeks.

The Committee registered its concern regarding the six unfunded Consultant costs required to fully implement the medical model. While mitigations were discussed, including the use of other professional groups to fulfil services, the Committee agreed that the Board must be made aware that some of the major community-based services cannot be staffed.

The Committee will continue to receive regular reports.

Maternity Improvement Plan

The Committee received an update on the progress of the maternity improvement plan. Whilst good progress is being made to meet the recommendations, there are still concerns regarding the culture – namely relationships between Doctors and Midwives, Doctors and Doctors, Midwives in hospital and community.

The Committee agreed that group therapy facilitated by psychologists could be helpful and this will be progressed by the Medical Director.

The Committee will continue to receive regular reports.

Prescribing Data

The Committee continued to discuss the use of medicine prescribing data as a quality indicator, specifically to ensure that systems and processes will direct prescribers to the safest practice and identify inappropriate prescribing. Currently, no resource is available to analyse and produce reports from the Electronic Prescribing Medication Administration (EPMA) system showing individual prescribing practice.

The Medical Director will be convening a meeting with the pharmacy to establish what data could be collected currently and whether this can be benchmarked. The Committee will receive an update at its next meeting.

Cannabis Prescribing

The Committee received an overview of cannabis prescribing in Jersey and noted that the prescribing rate is >100 higher than in the UK. Of most concern is firstly, the lack of regulation of the prescribing clinics; secondly, the prescribing of cannabis to those individuals with mental illness (as in a recent inquest); and thirdly, the public health risk due to the increased likelihood of individuals driving whilst under the influence of this group of drugs.

The Director of Mental Health, Intermediate and Social Care will raise this formally with the Minister for Health and Social Services and the Responsible Officer; the Committee supports this.

Board Assurance Framework

The Committee reviewed the relevant sections of the Board Assurance Framework (BAF) and agreed,

1. **Quality and safety**: The level of risk remains at 20. While the concerns regarding prescribing remain unresolved, the Committee has heard other areas of concern. Plans are in place to address these, and the assurance can be assessed over the next few months.

2. **Patient experience:** The committee agreed that the risk level has been reduced following today's report.

Matters to be referred to other groups/committees

Medicine Optimisation Committee: Support the development of prescribing quality indicators.

Executive Leadership Team: Conflict of interest. The current GOJ process relies on individuals determining whether they have a conflict rather than declaring all their interests in the first instance. This poses a risk for HCS, and the financial governance team have been asked for feedback on this issue.

Matters to be escalated to the HCS Advisory Board

1. **Central Alert System**: The Committee agreed that the lack of organisational oversight of equipment and consumable purchase (due to areas being able to purchase their equipment) must be escalated to the Board as this poses a significant risk for managing alerts related to equipment/consumables.

2. **Medical Model**: The lack of funding for the six medical Consultant posts required to fully implement the medical model means that some hospital / community-based services, such as care for the elderly, cannot be provided.

3. **Cannabis Prescribing**: The Committee is concerned regarding the lack of regulation of the prescribing clinics, secondly, the prescribing of cannabis to those individuals with mental illness (as in a recent inquest) and thirdly, the public health risk due to the increased likelihood of individuals driving whilst under the influence of this group of drugs.

The Committee wishes to highlight the improvements noted within the Maternity Services and Patient Experience.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Board Assurance Framework**		
Date of Meeting:	**25 July 2024**	**Agenda Item:**	**22**

Executive Lead:	Chris Bown, Chief Officer HCS
Report Author:	Emma O'Connor Price, Board Secretary

Purpose of Report:	Approval ☐	Assurance √	Information ☐	Discussion ☐
	This paper provides the Board with key strategic risks to the achievement of the annual strategic objectives 2024.			
Summary of Key Messages:	The key messages arising from this report are: Following the Committee meetings held at the end of June 2024, the following was agreed, - **Quality and Safety**: remains at 20. - **Patient Experience**: Reduced to 8 - **Operational Performance (Access)**: remains at 20 - **People and Culture**: Remains at 12 (although likely to increase) - **Finance**: Increased to 25			
Recommendations:	**The Board is asked to approve the risks and confirm that they are an accurate representation of the current significant risks to the delivery of HCS's strategic objectives.**			

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

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

List of Appendices:
Appendix 1: Board Assurance Framework

MAIN REPORT

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

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

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

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

BAF Review

Quality and Safety: The Quality, Safety and Improvement Committee met on the 27 June 2024. Whilst concerns remain regarding the lack of prescribing data to provide assurance regarding appropriate and safe prescribing, the Medical Director has been asked to provide an update at the next meeting as to what can be provided currently. The Committee also has heard other areas of concern, however there are plans in place to address these and the assurance can be assessed over the next few months. Agreement that the level of risk remains 20.

Patient Experience: The Quality, Safety and Improvement Committee met on the 27 June 2024 and considered a patient experience report which detailed a 48% decrease in patient complaints, continuing improvement in response times and an increase in recorded compliments. The Committee agreed that the level of risk has reduced from 12 to 8.

Operational Performance: The Finance and Performance Committee met on 26 June 2024. Whilst the committee received assurance regarding the management of urgent patients, the risk refers to all patient (urgent and routine); on this basis the Committee agreed the level of risk remains at 20.

Workforce and Culture: The People and Culture Committee met on 26 June 2024. Whilst there is agreement that the risk is higher than currently represented, further discussion required to agree the score.

Finance: The Finance and Performance Committee met on 26 June 2024. Until the £24.5million funding is approved by the Council of Ministers (COM), the level of risk has increased from 20 to 25. The impact of not receiving this funding will cause all BAF risks to increase.

New Risks Recommended for Inclusion in the BAF

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

Risks Accepted and De-Escalated from the BAF
No risks have been accepted or de-escalated from the BAF since the last Board meeting in May 2024.

Review Date
The BAF is reviewed bi-monthly by the Board and the committees of the Board. The next review date is scheduled for August / September 2024.

END OF REPORT

Health and Community Services

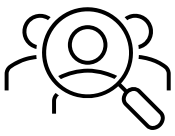
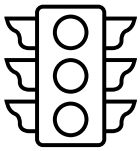
Board Assurance Framework

2024

The content of this report was last reviewed as follows:

Quality, Safety and Improvement Committee	June 2024
People and Culture Committee	June 2024
Finance and Performance Committee	June 2024
Executive Team	June 2024

How the Board Assurance Framework fits in

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

HCS Objectives

The Board has developed five key objectives for 2024.

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

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

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

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

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

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

Understanding the Board Assurance Framework

Risk Management Matrix:

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

Definitions:

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

Summary Position

Ref	Strategic Risk Summary	Executive Lead / Board Lead	Assurance Committee	Current Risk (L x C)	Change
1	**Quality and Safety** Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation.	**Medical Director** **Chief Nurse**	**Quality, Safety, and Improvement**	**20**	↔
2	**Experience** We are unable to meet the needs of patients because we fail to understand and learn from feedback (patients, service-users, carers) alongside other sources of intelligence.	**Chief Nurse**	**Quality, Safety, and Improvement**	**8**	↓
3	**Operational Performance** Our patients do not receive timely access to the care they need due to delays in treatment.	**Chief Operating Officer – Acute Services and Director of Mental Health Services and Adult Social Care** **Director of Improvement and Innovation**	**Finance and Performance**	**20**	↔
4	**Workforce and Culture** We are unable to meet the changing needs of patients and the wider system because we do not recruit, educate, develop, and retain a modern and flexible workforce and build the leadership we need at all levels.	**Director of Workforce** **Director of Culture, Engagement and Wellbeing**	**People and Culture**	**16**	↔
5	**Finance** We do not achieve financial sustainability including under delivery of cost improvement plans and failure to realise wider efficiency opportunities.	**Head of Strategic Finance**	**Finance and Performance**	**25**	↑

Risk Management

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

Impact

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

Strategic Objective			We will constantly review and compare our services to the best. We will learn and develop when we see good practice and when there are lessons to be learnt.			**Overall Assurance Level**	Medium
Monitoring Committee			Quality, Safety, and Improvement	**Board / Executive Lead**	Medical Director	**Date last reviewed**	27 June 2024
Risk ID	SR 1	**Risk**	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation.	**JCC Domain**	Awaited	**JCC Outcomes**	Awaited

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

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

Relevant Key Performance Indicators

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

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

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

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

Strategic Objective			We will drive a culture that places the patient at the heart of everything we do and champions the use of continuous improvement that is rooted in patient feedback.		**Overall Assurance Level**	Medium
Monitoring Committee			Quality, Safety, and Improvement	**Board / Executive Lead**	Chief Nurse	**Date last reviewed**	27 June 2024
Risk ID	SR 2	**Risk**	We are unable to meet the needs of patients because we fail to understand and learn from feedback (patients, service-users, carers) alongside other sources of intelligence.	**JCC Domain**	Awaited	**JCC Outcomes**	Awaited

Risk Rating: (Likelihood x Impact):5x4	
Initial risk score	20
Previous risk score	N/A
Current risk score	**8 (2 x 4)**
Tolerable risk	6
Direction of travel	N/A

Relevant Key Performance Indicators

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

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

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

Absence of Patient Charter	The absence of a patient charter, this piece of work will be started when the team is fully established.	Patient and Users Panel	Completed

Strategic Objective	We will drive improvements in access to high quality, sustainable and safe services.			**Overall Assurance Level**	Medium
Monitoring Committee	Operations, Performance and Finance	**Board / Executive Lead**	Chief Operating Officer – Acute Services, Director of Mental Health and Adult Social care and Director for Improvement and Innovation	**Date last reviewed**	26 June 2024
Risk ID SR 3	**Risk** Our patients do not receive timely access to the care they need due to delays in treatment.	**JCC Domain**	Awaited	**JCC Outcomes**	Awaited

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

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

Relevant Key Performance Indicators

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

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

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

					Mental Health and Adult Social Care	
Strategic Objective			We will lead and support a high performing workforce. We will create a well-led and great place to work.		**Overall Assurance Level**	Medium
Monitoring Committee			People and Culture	**Board / Executive Lead**	Director of Workforce, Director of Culture, Engagement and Wellbeing	**Date last reviewed**	26 June 2024
Risk ID	SR 4	**Risk**	We are unable to meet the changing needs of patients and the wider system because we do not recruit, educate, develop, and retain a modern and flexible workforce and build the leadership we need at all levels. We are unable to develop and maintain a workplace culture in line with *Our Values, Our Behaviours* including promoting equality, diversity and inclusivity and prioritising the health and wellbeing of staff because we do not enable a co-ordinated structure and approach to organisational development.	**JCC Domain**	Awaited	**JCC Outcomes**	Awaited

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

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

Relevant Key Performance Indicators

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

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

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

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

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

Strategic Objective			We will ensure effective financial management through budget planning, monitoring/reporting and delivery of HCS services within agreed financial limits.			**Overall Assurance Level**	Medium
Monitoring Committee			Operations, Performance and Finance Committee	**Board / Executive Lead**	Finance Lead	**Date last reviewed**	26 June 2024
Risk ID	SR 5	**Risk**	We do not achieve financial sustainability including under delivery of cost improvement plans and failure to realise wider efficiency opportunities.	**JCC Domain**	Awaited	**JCC Outcomes**	Awaited

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

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

Relevant Key Performance Indicators

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

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

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

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