Health and Community Services

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

6TH DECEMBER 2023 9:00AM – 1:10PM

Government of Jersey

Health and Community Services

AGENDA

MEETING: Part A - Health and Community Services Advisory Board
DATE: Wednesday 6th December 2023
TIME: 9:30am – 1:10pm
VENUE: Main Hall, St Paul's Centre, Dumaresq Street, St Helier, Jersey JE2 3RL

	Description	Owner	Time
OPENING ITEMS			
1	**Welcome and Apologies**	Chair	**9:30am**
2	**Declarations of Interest**	Chair	
3	**Minutes of the Last Meeting**	Chair	
4	**Matters Arising and Action Tracker**	Chair	
5	**Chair's Introductions**	Chair	
6	**Chief Officer's Report**	Chief Officer	
QUALITY AND PERFORMANCE			
7	**Quality and Performance Report (Month 10)** *Paper*	Chief Operating Officer – Acute Services, Director of Mental Health Services and Adult Social Care, Medical Director and Chief Nurse	**9:55am**
8	**Waiting List Report - Acute Services** *Paper*	Chief Operating Officer – Acute Services	**10:25am**
9	**Finance Report (Month 10)** *Paper*	Finance Lead – HCS Change Team	**10:35am**
10	**Workforce Report (Month 10)** *Paper*	Associate Director of People	**10:50am**
11	**Recruitment (Long term approach)** *Paper*	Associate Director of People	**11:05am**
12	**Medical Job Planning** *Paper*	Medical Director	**11:15am**
13	**Winter Plan 2023** *Paper*	Chief Operating Officer – Acute Services	**11:25pm**

		Director of Mental Health Servies and Adult Social Care	
GOVERNANCE			
14	**Serious Incidents Position Statement** *Paper*	Medical Director	**11:35am**
15	**Acute Medicine** *Paper*	Chief Operating Officer – Acute Services	**11:45am**
16	**Maternity Improvement Plan (MIP) Workstreams** *Paper*	Medical Director	**11:55am**
17	**Infection Prevention and Control (IPAC)** *Paper*	Chief Nurse and Medical Director	**12:05am**
18	**General Surgical Rota** *Verbal*	Medical Director	**12:15am**
CULTURE			
19	**Freedom to Speak Up Guardian Report** *Paper*	Freedom to Speak Up Guardian	**12:25pm**
20	**Cultural Change Programme: Improvement Plan** *Paper*	Director of Culture, Engagement and Wellbeing	**12:40pm**
QUESTIONS FROM THE PUBLIC (Related to Agenda Items only)			
21	**Questions**	Chair	**12:55pm**
	MEETING CLOSE **Date of next meeting:** 25th January 2023	Chair	**1:10pm**

Health and Community Services Department Advisory Board

Health and Community Services

Date: 1 November 2023	Time: 9:00 – 11:00pm	Venue: Main Hall, Dumaresq St, St Helier, Jersey JE2 3RL

Board Members:		
Professor Hugo Mascie-Taylor - **CHAIR**	Fixed-Term Chair of the Board	**HMT**
Carolyn Downs CB	Non-Executive Director	**CD**
Anthony Hunter OBE	Non-Executive Director	**AH**
Dr Clare Gerada	Non-Executive Director (TEAMS)	**CG**
Mr Patrick Armstrong	Medical Director	**PA**
Jessie Marshall	Chief Nurse	**JM**
Claire Thompson	Director of Clinical Services	**CT**
Andy Weir	Director of Mental Health Services and Adult Social Care	**AW**
Anuschka Muller	Director of Improvement and Innovation	**AM**
Cheryl Power	Director of Culture, Engagement and Wellbeing	**CP**
Steve Graham	Associate Director of People HCS	**SG**
Obi Hasan	Finance Lead – HCS Change Team	**OH**
In Attendance:		
Beverley Edgar	Workforce Lead – HCS Change Team	**BE**
Emma O'Connor	Board Secretary	**EOC**
Sophie Bird	Head of Communications HCS	**SB**
David Hopkins	(Interim) Chief of Service Women, Children and Family Care (Item 15 only)	**DH**
Adrian Noon	Chief of Service Medical Care Group (Item 14 only)	**AN**

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

HMT welcomed all to the meeting and stated that the meeting time had been reduced in length due to the forecast adverse weather conditions.

HMT explained that once fully established, the Board will consist of a Chair, five Non-Executive Directors (NEDs) and five voting Executive Directors (noting that in practice, issues rarely come to a vote). The substantive Chair and two remaining NEDs will be announced through the usual communication channels once appointed.

The voting Executive Directors (EDs) are,

- Chief Officer HCS
- Medical Director
- Chief Nurse
- Human resources Director
- Finance Director

Noting that the recruitment of the substantive Chair is underway, HMT advised that this will be his last meeting as Chair. Firstly, HMT wishes all well in future Board meetings, emphasising the purpose of the Board is to serve the people of Jersey and provide the best possible health and social care. Secondly, HMT thanks those who supported the set-up of the Board.

HMT welcomed Dr Clare Gerada to her first Board meeting as NED (attending by Teams due to the adverse weather conditions). CG introduced herself to the Board and provided a brief summary of career,

- General Practitioner (GP) and Psychiatrist by training
- President of the Royal College of GPs

CG expressed her enthusiasm in joining the Board and meeting other members and hopes to bring to the Board an expertise of working in a healthcare sector for 40 years.

Noting the quality of NEDs that Jersey has been able to attract, HMT highlighted that Jersey is very fortunate.

Apologies received from:

Christopher Bown	Chief Officer HCS	CB
Simon MacKenzie	Medical Lead – HCS Change Team	SMK
Cathy Stone	Nursing and Midwifery Lead – HCS Change Team	CS

2	**Declarations of Interest**	**Action**
No declarations.		

3	**Minutes of the Previous Meeting**	**Action**
The minutes of the previous meeting held on 4th October were agreed. AH advised that he had met with AW and the Chief Social Worker on 31st October who are all committed to developing a suite of indicators which reflect what the Board is trying to achieve for the community and social care. The full suite of indicators will be developed through 2024 but there will be a core set in preparation for January 2024: some of the metrics will allow benchmarking against similar organisations.		

4	**Matters Arising and Action Tracker**	**Action**
ACTION 70: AW explained that it is anticipated that the Prosecution Policy will be ratified in January 2024 and will be ready for the presentation to the Board in February 2024. General discussion followed regarding the function of the Policy and Procedure Ratifying Group (PPRG), and it was clarified that the Board does not ratify policies, this is done by the relevant profession(s). **ACTION 64**: PA advised that the Quality and Safety Team distribute NICE Guidance to the relevant team(s) as it is released and then seek assurance that it is being followed. This is also monitored through the new care group governance reviews. A look-back exercise is required to ensure compliance with previous NICE Guidance, but this is recognised to be a large piece of work. The implementation of the new electronic system for monitoring guidelines will help to support this. HMT asked if NICE / International Guidance is more welcomed across HCS than previously. PA responded that it is and the recruitment of practitioners (Doctors) who have trained in the UK are much more used to following this type of guidance. However, it is important to recognise that NICE may not always be the most up-to-date and there have been two requests to follow European Guidance. HMT stressed that any exceptions to following guidelines must be presented to the Board so that the people of Jersey understand that the Nationally / Internationally approved guideline is not being followed in Jersey and they understand why it is not being followed. ACTION: PA / JMa to present the progress of this work to the Board and what extent the Board can be assured that compliance is occurring. To include guidance for other professions (January 2024). **ACTION 62:** Discussions have taken place with the Royal College of Surgeons (RCS) and now in the process of agreeing the terms of reference for the review. The RCS have indicated that once the terms of reference have been agreed, it will be approximately three months before the review will commence (end Jan / Feb 2024).		

ACTION: PA to provide an update on progress at the next Board meeting (Dec 2023) (to include the terms of reference if agreed).

ACTION 59: The Picker Survey has commenced (post / electronic form) and is due to be completed by 19th January 2024. The survey has been distributed to 5,800 patients. It is likely that a report on the results will be available to present to the Board in March 2024. However, a further verbal update can be given at the Board in December 2023.

CG asked how Picker are going to be drilling down into concerns from patients for example, discharge planning. JMa explained that Picker will be undertaking five surveys, and the questions are based on Care Quality Commission (CQC) inspections with some Jersey specific questions.

ACTION: The previous Picker Survey on Patient Experience and the questions in the current survey to be provided to the NEDs.

ACTION 55: SG in full agreement with the thoughts expressed by AH. There is now an opportunity with the addition of resource to start to look at person specification within job descriptions and will discuss this further with AH to understand how it has been done in other organisations. AH will make contact with SG to discuss his experience of doing some work regarding inclusive recruitment.

ACTION 52: AM stated that the metrics for 2024 are under review with the support of the change team. Following the internal governance process, the proposed suit of metrics will be presented to the Board in January 2024 for approval.

ACTION 51: Discussed in item 3 as matters arising.

ACTION 50: A copy of the readmission deep dive was sent to the NEDs.

ACTION 8: Estates and New Health Care Facilities (NHF) will be incorporated in a Board Workshop.

ACTION 6: CD noted that challenges following the implementation of the Electronic Patient Record (EPR) were raised in a number of papers during the last Board and requested a paper for the next meeting. CT gave a brief summary to provide assurance that the EPR is not causing any safety issues, specifically within ITU / ED.

Noting that this action is specifically about the recommissioning of an EPR for Mental Health (MH), Social Care and Community Physical Health Services that use an alternative system. This is a formal Government of Jersey (GOJ) process in very early stages and likely to take a year before awarding a provider.

CD explained that in a number of areas, the delayed introduction of the EPR is detailed as the reason why targets are not being achieving. Therefore it would be useful to understand when this is likely to be resolved to see the impact on the target.

Reflecting that the overriding guiding principle for the procurement of an EPR is a system which makes the most sense to the patients for who we are trying to deliver care. AW provided assurance that service-user consultation is an integral part of the procurement process. HMT asked to AW and AH to liaise further.

ACTION: A detailed paper on the EPR to be presented at the next Board meeting (December 2023).

ACTION: Following CG's request, AW to produce a briefing on the system specification (to include interoperability) and OH to provide a briefing for the NEDs on the procurement process (Dec 2023).

ACTION 2: The assurance committees will be discussed at the planned Board workshop on 5th December 2023.

HMT welcomed the Minister for Health and Social Services (MHSS) to the meeting.	

5	Chair's Introductions	Action
See item 1.		

6	Chief Officer's Report	Action
CB's apologies noted. Most of the issues highlighted in this report are discussed in further detail in today's agenda. However, HMT asked Board members to raise any issues that are not covered, Noting the reference to the BeHeard Survey, CD suggested it would be useful for the NEDs to receive a copy of HCS's results. In addition, it would be helpful to know how many staff have referred concerns through the Freedom To Speak Up Guardian (FTSU). ACTION: CP to share the BeHeard survey results with the NEDS. HMT advised that whilst unable to give an exact the number, the referrals to the FTSU Guardian exceeds 20, indicating that the service is being used and the process is proving to be valuable. As Chair, HMT meets with the FTSU Guardian at least fortnightly and direct access to a NED should be a future consideration (to maintain independence of the role). In response to CD's suggestion that it would be useful for the Board to receive a report from the FTSU Guardian, HMT advised this has been discussed and a theme-based report is considered appropriate for in the Part A meeting, with more detailed discussions in Part B if required. ACTION: FTSU Guardian to produce a thematic report for a future Board meeting (December 2023).		

7	Quality and Performance Report Month 9	Action
Areas of focus, **Elective Theatre Utilisation** This metric has been impacted by the implementation of the new EPR, but these issues are being managed. In addition, data capture has also been impacted for a variety of other reasons e.g., the emergency theatre list has previously been included in elective theatre utilisation (since removed). A description of the work being undertaken to improve theatre utilisation was provided including, close working between Head of Planned Access and Theatre, weekly 6-4-2 meetings and look back review at week-end. HMT asked how improved elective theatre utilisation can be demonstrated through the metrics. It was noted that this metric includes both public / private patient theatre utilisation. Agreement that decisions must be made according to patient safety and patient urgency rather than whether patients are paying for services. CT reassured the Board that decisions are made based on safety and urgency. It was also noted that optimising theatre utilisation (which is a key measure of operational performance) is critical to the success of the financial recovery programme. OH advised the Board that there is detailed plan and trajectory to support theatre utilisation which is monitored. ACTION: Elective Theatre Utilisation to be split according to public / private (December 2024). **% patients waiting over 90 days for 1st out-patient (community).** The services predominantly sitting in this metric are community dental and physiotherapy. The percentage of patients waiting over 90 days for 1st outpatient appointment continues to decrease driven by two main initiatives,		

1. Social recovery bid. HCS has commissioned community private dentist to provide dental care to children. This has had a significant positive impact upon the waiting list. However, there is a risk to the service as funding is limited and HCS Dental Department does not have capacity to continue to provide community dental treatment for children.
2. Successful recruitment within Physiotherapy and job planning has increased capacity.

Noting that waiting lists have been impacted globally by the covid-19 pandemic, CD advised it would be useful to clearly understand which areas HCS are specifically targeting to make an impact. Also, for those who have been waiting over 90 days, how can the Board be assured regarding assessment of harm of those whilst waiting, i.e., how is potential clinical harm as a result of the long waits being assessed and how does this inform decision-making for treatment prioritisation. CT responded that the waiting list recovery scheme (developed Jan 2023) sought to address those areas with greatest clinical risk and secondly, areas with the longest waits.

Regarding community dental services, PA advised the Board that historically there have been very long waits in this area and the only free provision for children's dental care is up to secondary school age. The scheme that was put in place (described above) has had a significant positive impact on this. Jersey has signed up to the United Nations Charter for Children's Rights, part of which is to provide free health and dental care to all under the age of 18 years. This will be difficult for HCS to manage without financial and political support.

ACTION: PA / CT to provide a separate briefing paper detailing the funding issue regarding the Community Dental Scheme and what the implications are (December 2023).

New to follow-up ratio
Speciality detail is reviewed at the Care Group Performance Review meetings.

ACTION: The same areas of focus (elective theatre utilisation, % patients waiting > 90 days and new to follow up ratio) will be considered at the next meeting (December 2023), detailing the trend (numerically), when does HCS anticipate reaching the target and what do we know about the effect on patients (rather than a description of process).

8	**Finance Report Month 9**	**Action**

The Board received an overview of the Month 9 position. Key highlights,

- The year-to-date (YTD) position is £23.1 million.
- FY 23 year-end forecast remains deficit of £29 million.
- The main drivers of the YTD position are staff costs (£8.4 million), non-pay (£14.2 million) and income under0achievement (£0.6million).

The Financial Recovery Programme (FRP) has clearly identified specific drivers and mitigations are in place to manage these in the short and long term. Some of the financial difficulties that HCS are facing are a consequence of operational inefficiencies which are being addressed such as bed capacity and patient flow.

HCS has committed to deliver the £25 million over three years (of the overall £35 million deficit)., Hoping to report next month a £3 million saving in-year which is a great achievement for both the FRP and engagement of care groups.

There are risks to the £29million position, namely the reserve position which has reduced to £1.78 million. A £9 million saving must be made to get to the £26 million: £3 million is visible as the schemes are known however, there are unanticipated cost pressures (legacy of financial operations and care delivery). As these are identified, they will be managed.

HMT asked if the reserves have been used to deal with the unexpected cost pressures or are they being used beyond this. OH responded that the reserves are being used to manage the unexpected cost pressures as they arise and then seeking to mitigate these moving forward. However, if the reserves were not used, the underlying deficit would increase by £9million.

Noting the £3million saving achievement, CD asked if the work of the care groups has identified true efficiency savings rather than cost reduction saving. OH advised this will be determined when the run rate (difference between income and expenditure monthly) starts to decrease and although there is an indication that this is happening, it will need to be monitored over the next three months. Recognising that agency staff usage is a global issue, CG asked what action is being taken to address this. OH responded that the FRP has been working closely with the care groups to understand what the recruitment delays are, some of which are and are not in the control of HCS. SG advised that where this are long term agency staff this is due to low activity in the recruitment market and substantive recruitment activity has now increased. In addition, agency staff tens to feel heard to recruit roles and recruitment is taking place but not necessarily into posts currently filled by agency staff. However, there is a focus to recruit substantively and reduce agency costs with multiple workstreams. OH emphasised that this is a focus of the FRP. Noting the opening of 18 new beds (beginning of November 2023) to improve patient flow, reduce length of stay and increase income from private elective activity, HMT asked what the predicted effect on theatre utilisation is. OH responded that the trajectory is to increase to between 80-85%. The data to demonstrate the impact will be available at the meeting of the Board in February 2024 (review of January 2024 performance).	

9	**Workforce Report Month 9**	**Action**
Recruitment activity: As well as the increase in funded establishment across all pay groups, there are more staff in post this year. However, a significant number of vacancies do remain, though several of the initiatives to address this are having a positive impact. Performance across the recruitment process is being measured and anticipating that this 'pipeline' information will be available for the meeting in December 2023 i.e., how many individuals who are going through clearance. ACTION: Workforce report in December 2023 to include 'pipeline' information. **Exit Interviews**: The HCS team have been offering face-to-face exit interviews to all staff who resign but there has been a low uptake. From those who do attend an interview, cost of living, training, communication and management style contribute to leaving, however, these numbers are every low. An external on-Island company have been commissioned to contact all leavers to offer an exit interview / discussion which is completely independent of Government of Jersey (GOJ). The focus will be on HCS initially. In response to CD's question regarding the availability of results from these, SG responded that this data should be available during Q1 2024. ACTION: SG to include the data from the exit interviews in future workforce reports (March / April 2024). The GOJ HR analytics teams have generated a dashboard of leavers information which will provide useful information monthly. AH commented that understanding the experience of those who stay in addition to those who leave, is very valuable. SG advised this there is an intention to conduct 'stay interviews' as seen in other jurisdictions.		

10	**Serious Incident (SI) Position Statement**	**Action**
Following the report presented during October 2023, PA advised, • An interim investigator is due to start in the next couple of weeks ago with a focus on investigations that have stalled or have not started. Hopefully, the impact of this will be seen by the end of 2023.		

- An external investigation company have been commissioned to do a review of 19 cases massive obstetric haemorrhage (MOH) and this should be staring soon.
- The 2nd quality and safety learning event has been held this month with over 100 staff attending.
- Patient safety week has been held.
- There is greater oversight of SI recommendations and whilst a high number remain outstanding, this has reduced from 320 to 220.

CD asked if an incident were to cause severe harm to a patient (noting a patient sustained severe harm following a fall), is there still difficulty in sourcing an investigator to review the case. PA responded that there is immediate learning following a round table review which would then be presented to the SI panel who would then determine if an SI investigation is also required. PA feels that there is better engagement in the round table reviews, but sourcing investigators remains a challenge.

Noting that the paper refers to the SLT being asked to consider the offer of additional payment for staff to carry out investigations, HMT asked if the Consultants continue to receive 10 hours / week supporting programmed activity (SPAs) time. PA responded that the amount of time is variable but in agreement that investigating SIs should be included in SPA time. However, it was recognised that other registered practitioners should also be investigating SIs. HMT noted a requirement to be more directive regarding SPA time rather than spend additional money.

11	**Complaints Position Statement**	**Action**
Deferred (due to shortened agenda).		

12	**Waiting List Report**	**Action**
Specifically addressing the question of how the £5 million allocated to address the waiting lists has been spent, CT responded that £2.7 million is forecast to be spent at end 2023. CT explained that some of the delays include compliance with the GOJ procurement process – it took 3 months for the current endoscopy initiative to reach the Procurement Board. ACTION: OH to include the challenges / delays regarding the current procurement process in the briefing paper (on procurement) (Dec 2023). HMT noted that if the process for spending allocating money is so protracted that it is not spent, this does not benefit patients. CG advised that there is a lot of emerging evidence regarding different ways of reducing waiting lists and whether this could be looked at in more detail, for example, group consultations. ACTION: CT to link with CG to discuss waiting list management strategies further.		

13	**Job Planning**	**Action**
Paper taken as read. Key highlights, • Progress has been made in signing off job plans, and the data is now reported differently to make it clearer who has an in-date job plan. • Of concern, are the number of job plans that remain 'in discussion'. This lack of progress appears to be multi-faceted including lack of understanding of the process, reduction of paid sessions and consistency working across rotas. PA will be working with the Deputy Medical Director over the next 4-6 weeks to support the care groups, Chiefs of Service and Clinical Leads to focus on this. Referring to the discussion started in item 10 (SI Report), PA advised that individuals understanding of what should be completed in SPA time is challenging i.e., what activities should be undertaken in SPA time and where these activities should be undertaken.		

CD asked how disputes with job plans are mediated and resolved. PA responded that a consistency panel is held fortnightly, and an appeals process is described in the policy. However, as only one concern has been raised to-date. Noting that approximately 10% of all job plans went to an appeal process when introduced over 20 years ago in the UK, and contrasting this with Jersey, HMT suggested job planning was not being driven to the point where either they are agreed or disagreed, to then follow the appeals process. PA in agreement and this is why himself and the Deputy Medical Director will be intervening (as described above). HMT concerned that the Board cannot be assured as to whether public money is being spent appropriately or inappropriately. In conclusion, if an issue with a job plan cannot be resolved (for what might be a good reason), then this must go to an appeals process. ACTION: The next report (Dec 2023) to include how many of the issues that have not been resolved (in years) are going into the appeals process (to resolve the issue for both the Doctor and HCS).	

14	**Acute Medicine**	**Action**
Dr Adrian Noon, Chief of Service for Medicine in attendance for this item. HMT asked AN if the action plan has timescales attached. CT responded this is the correct and the Royal College of Physicians (RCP) suggested timescales within the report. ACTION: The action plan and timescales to be included in the next report (December 2023).		

15	**Maternity Improvement Plan (MIP) Workstreams**	**Action**
Dr David Hopkins, Chief of Service for Women, Children and Family Care in attendance for this item. The paper details an update on the progress of the Maternity Improvement Plan (MIP). THE MIP is a comprehensive plan that considers all recommendations made by external reports and best practice reports from the UK. The plan is progressing at pace. Culture remains a significant issue and it is recognised that there is a need for cultural change, particularly regarding stronger multiprotection working. Several options for external support are being explored to support culture improvement. An ambitious programme of multi-professional training has been developed and started. There is a focus on skills and drills training to ensure that the teams are working well together for the management of emergency situations. The development of the metrics to monitor maternity services continues. PA extended his thanks to Dr Hopkins and his leadership team for the progress made with the MIP. There is a greater confidence in the amount of progress that is being made. HMT gave his thanks for the report and suggested that the format is used as a model for other reports.		

16	**Infection Prevention and Control (IPAC) Audit Improvement Work**	**Action**
Staff that receive their flu / covid vaccination out with HCS are not recorded in the HCS data, so it is unknown what percentage of the workforce is vaccinated against flu / covid. However, data at end-Oct 2023, the flu vaccination rate has increased to 25% (from 13.4%) and covid vaccine uptake has increased to 24% (from 12%). The team continue to offer the vaccinations across the HCS sites. HMT asked if there is benchmark data for the vaccinations and does HCS have a target?		

ACTION: HMT asked JM if HCS can set a target (recognising that any target may be debatable) and secondly, can HCS obtain any intelligence about how many staff have been vaccinated in primary care settings (Dec 2023).	

17	Safeguarding Report (Verbal)	Action
AW provided a verbal summary of current position. The Adult Safeguarding function for jersey sits with HCS Adult Social Care and there has been a 47% increase in referrals since beginning of 2022 with no resultant budget / capacity increase. The team is small and stretched and consequently reports to AW on a regular basis to provide assurance that referrals are being managed. The general manager for Audit Social Care intended to carry out an audit on the outcomes following safeguarding interventions using the Making Safeguarding Personal Framework. HCS is not in a position to do this today however, the audit will be completed by the end of 2023 for presentation to the Board in February 2024. ACTION: The Safeguarding Audit results to be presented to Board in February 2024 Noting the 47% increase, AH what number does this represent. AW responded that during Q1 and Q2, 200-220 referrals were received, leading to an end of year forecast of approximately 900 referrals. However, in the absence of a Care Act, the legislative framework in Jersey is very different form the UK and the referrals differ. However, a large percentage of the referrals do not result in further investigation. In addition, a large percentage of referrals related to vulnerability and self-neglect. In response to AH's questions, AW confirmed that the increase in referrals will be due to increased awareness of safeguarding issues.		

18	Board Timetable 2024	Action
The dates of the next meetings confirmed as, • Wednesday 6th December 2023 • Thursday 25th January 2024 The timetable for 2024 / 2025 will be uploaded to the website this afternoon.		

19	Questions from the Public	Action
Question 1 Why are the 'social' rooms at the end of each ward which were historically available to all patients well enough to get themselves up and move around, not available for patients to use whilst waiting for their meds so that the beds they had been occupying could be utilised for patients on the waiting list? **Answer 1** As part of the work undertaken to improve patient flow, clinical teams are requested to complete the prescriptions as soon as there is an estimated date of discharge (EDD), however, this requires further improvement. There are initiatives regarding discharges, particularly those leaving hospital in the morning or using patient transport at a specific time. There are only two wards with day rooms, Beauport Ward and the Surgical Floor. The potential of a Discharge Lounge is being explored as part of the HCS Winter Plan 2023 / 2024. However,		

HMT clarified that where there are social rooms available, these can be used by the groups of patients being referred to in the question. The use of community pharmacies to fulfil hospital prescriptions is complex and has been explored by HCS previously, however, it is not financially viable. CG noted this is an example of how systems have not been designed to support the patient. ACTION: HMT requested a paper explaining where all the delays occur in the discharge process, including hospital pharmacy versus community pharmacy. **Question 2** Noting the £5million waiting list funding, why can care not be outsourced from international settings? **Answer 2** HMT noted this has in part been answered through the agenda and there is a significant procurement issues in Jersey. The Board has requested a paper on the procurement process i.e., what are the factors that mean HCS is failing to spend the money allocated to recover the waiting lists. **Question 3** Referring to personal experience, it was noted that there seems to be a number of wasted appointments (due to lost notes, lack of results etc.) and could this be contributing to the length of the waiting lists? HMT suggested that PA / JM speak directly to the member of public to address the specific issues raised and establish what lessons HCS can learn. CG offered to speak to the person concerned to understand her experience of care and suggested that these issues are examples of those that NEDs should be focussing on. ACTION: JM / PA to contact member of public to discuss concerns raised.	

	MEETING CLOSE	**Action**
Date of next meeting: Wednesday 6th December 2023		

	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	95	1st Nov 2023	17	Safeguarding Report	The Safeguarding Audit results to be presented to Board in February 2024	Andy Weir	Feb-24				Future Agenda
5	94	1st Nov 2023	19	Questions from the public	JM / PA to contact member of public to discuss concerns raised.	Jessie Marshall / Patrick Armstrong	Dec-23	Update 27 Nov 2023 Meeting has been arranged and will have taken place by the next meeting of the Board on 6th December 2023.			Discussion
6	93	1st Nov 2023	19	Questions from the public	HMT requested a paper explaining where all the delays occur in the discharge process, including hospital pharmacy versus community pharmacy.		Jan-23				Future Agenda
7	92	1st Nov 2023	16	Infection Prevention and Control (IPAC) Audit Improvement Work	HMT asked JM if HCS can set a target (recognising that any target may be debatable) and secondly, can HCS obtain any intelligence about how many staff have been vaccinated in primary care settings.	Jessie Marshall	Dec-23				Todays agenda
8	91	1st Nov 2023	14	Acute Medicine	The action plan and timescales to be included in the next report (December 2023).	Claire Thompson	Dec-23				Todays agenda
9	90	1st Nov 2023	13	Job Planning	The next report to include how many of the issues that have not been resolved (in years) are going into the appeals process (to resolve the issue for both the Doctor and HCS).	Patrick Armstrong	Dec-23				Todays agenda
10	89	1st Nov 2023	12	Waiting List Report	CT to link with CG to discuss waiting list management strategies further.	Claire Thompson	Dec-23				Discussion
11	88	1st Nov 2023	9	Workforce Report Month 9	SG to include the data from the independent exit interviews in future workforce reports (March / April 2024).	Steve Graham	March / April 2024				Future Agenda
12	87	1st Nov 2023	9	Workforce Report Month 9	Workforce report in December 2023 to include 'pipeline' information.	Steve Graham	Dec-23				Todays agenda
13	86	1st Nov 2023	7	Quality and Performance Report Month 9	The same areas of focus will be considered at the next meeting (December 2023), detailing the trend (numerically), when does HCS anticipate reaching the target and what do we know about the effect on patients (rather than a description of process).	Claire Thompson	Dec-23				Todays agenda
14	86	1st Nov 2023	7	Quality and Performance Report Month 9	PA / CT to provide a separate briefing paper detailing the funding issue regarding the Community Dental Scheme and what the implications are.	Claire Thompson	Dec-23				Discussion
15	85	1st Nov 2023	7	Quality and Performance Report Month 9	Elective Theatre Utilisation to be split according to public / private	Claire Thompson	Dec-23				Todays agenda
16	84	1st Nov 2023	6	Chief Officer's Report	FTSU Guardian to produce a thematic report for a future Board meeting.	Chris Bown	Jan-24				Future Agenda
17	83	1st Nov 2023	6	Chief Officer's Report	CP to share the BeHeard survey results with the NEDS.	Cheryl Power	Dec-23				Discussion
18	82	1st Nov 2023	4	Electronic Patient Record	Following CG's request, AW to produce a briefing on the system specification (to include interoperability) and OH to provide a briefing for the NEDs on the procurement process.	Andy Weir / Obi Hasan	Dec-23				Todays agenda
19	81	1st Nov 2023	4	Electronic Patient Record	A detailed paper on the EPR to be presented at the next Board meeting (December 2023).	Claire Thompson	Dec-23				Todays agenda
20	80	1st Nov 2023	4	Picker Survey	The previous Picker Survey on Patient Experience and the questions in the current survey to be provided to the NEDs.	Jessie Marshall	Dec-23				Discussion
21	79	1st Nov 2023	4	Picker Survey	A further verbal update can be given at the Board in December 2023 (link to action 59).	Jessie Marshall	Dec-23				Discussion
22	78	1st Nov 2023	4	General Surgical Acute Rota	PA to provide an update on progress at the next Board meeting, to include the terms of reference if agreed (link to action 62).	Patrick Armstrong	Dec-23				Todays agenda
23	77	1st Nov 2023	4	National Institute for Health and Clinical Excellence (NICE) / Royal College Guidelines	PA / JMa to present the progress of this work to the Board and what extent the Board can be assured that compliance is occurring. To include guidance for other professions (Link to action 64).	Patrick Armstrong / Jessie Marshall	01-Jan-24				Future Agenda
24	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-Feb-24				Future Agenda
25	74	04-Oct-23	27	Statutory and Mandatory Training Needs Analysis	An update to be provided to the Board in January 2024	A. Weir / J. Marshall	Jan-24				Future Agenda
26	73	04-Oct-23	25	Management of Policy Documents and Procedural Guidelines	A position statement to be presented in January 2024 regarding the suite of corporate policies that help to provide assurance that HCS is safe, well-led and effective.	C. Bown	Jan-24				Future Agenda
27	72	04-Oct-23	24	Mental Health and Capacity Legislation – Report from the Multi-Agency Assurance Group	It was agreed that this report is presented to Board on a 6 monthly basis (March 2024).	A. Weir	Mar-24				Future Agenda

	A	B	C	D	E	F	G	H	I	J	K
28	71	04-Oct-23	23	Update on the 61 recommendations from the Review of Governance Arrangements within Secondary Care (2022) by Professor Hugo Mascie-Taylor	Quarterly report Update on the 61 recommendations from the Review of Governance Arrangements within Secondary Care (2022) by Professor Hugo Mascie-Taylor to be presented to the Board.	A. Muller	Jan-24				Future Agenda
29	69	04-Oct-23	21	Cultural Change Programme	The Board to receive the improvement plan for culture in December 2023 including what success looks like and the differences that have been made.	C. Bown / C. Power	Dec-23				Todays agenda
30	68	04-Oct-23	20	Appraisal and Revalidation for Doctors – Position Statement	The Board to receive an update in January 2024.	P. Armstrong	Jan-24				Future Agenda
31	66	04-Oct-23	18	Maternity Improvement Plan (MIP) Workstreams	The Board to receive a monthly report with specific progress against the targets that have been set, including any general comments about culture issues.	P. Armstrong	Nov-23	Agenda item 15 at meeting on 1st November			Todays agenda
32	61	04-Oct-23	13	Waiting List Report	HMT asked for there to be a focus on six of the areas where patients experience long waits and detail the constraints, how these are managed and the timeline for resolution (December 2023).	C. Thomspon	Dec-23				Todays agenda
33	58	04-Oct-23	11	Serious Incident (SI) Position Statement	Future SI papers to include the themes that arise for SIs, the changes that need to be as made as a result of these themes, who is responsible for enacting the change (at Executive Director level), and how do we know that the change has occurred (December 2023).	P. Armstrong	Nov-23	Agenda item 10 at meeting on 1st November			Todays agenda
34	56	04-Oct-23	10	Workforce Report Month 8	The Board to receive a report detailing the longer-term approach to recruitment across HCS (December 2023).	C. Bown / S. Graham	Dec-23				Todays agenda
35	54	04-Oct-23	8	Quality and Performance Report Month 8	To determine who is accountable at Executive level for the exception reports detailed at the back of the Quality and Performance Report (December 2023).	C. Bown	Dec-23				Todays agenda
36	52	04-Oct-23	8	Quality and Performance Report Month 8	Executive Directors to review the current suite indicators, standards set and quality of data to provide assurance that the data is meaningful and directs activity (date to be advised by CB).	C. Bown	January 2024 ~~01/11/2023~~	Update 1st Nov AM stated that the metrics for 2024 are under review with the support of the change team. Following the internal governance process, the proposed suit of metrics will be presented to the Board in January 2024 for approval.			Future Agenda
37	31	10-Jul-23	13	Finance Report – Month 5	HMT and CB will discuss the lack of budgetary information available to budget holders with KPMG.	H. Mascie Taylor / Chris Bown	December 2023 ~~01/10/2023~~	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.			Discussion

Health and Community Services

Health and Community Services Advisory Board Report

Report to:	Health and Community Services Advisory Board		
Date of meeting:	Wednesday 6th December 2023		
Title of paper:	Chief Officer Report		
Report author (& title):	Chris Bown, Chief Officer	**Accountable Executive:**	Chris Bown, Chief Officer

1. Purpose

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

2. Executive Summary

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

3. Main Report

Winter Planning

Key actions have been taken to support HCS' response to seasonal variation in demand for services. This year's winter plan builds on learning from previous plans. Winter 2023/24 is the first winter period following Covid where HCS has additional acute inpatient bed capacity. Actions in the plan include improvements to ambulatory pathways and weekly meetings to promote good discharge and flow to nursing and domiciliary care.

Delayed Transfers of Care

Delayed transfers of care (DToC) have slowly reduced over the last two months with an average number of patients waiting in November between 27 and 30 (compared with over 40 patients waiting in September). The primary reasons for delay include waiting for either nursing home beds and/or a packages of care. Following approval by HCS Senior Leadership Team (SLT), a detailed plan will be presented at the January 2024 Board.

In conjunction with Customer and Local Services (CLS), a pilot care package brokerage system commences on the 27 November 2023 with the aim to ensure efficiency, accuracy, and transparency in matching care recipients with suitable care providers through a secure and accessible spreadsheet platform.

Financial Recovery Plan and M10 Finance

The Year-to-date (YTD) actual vs budget overspend has increased by £2.5m in M10 to £25.6m, showing a slowing down of £0.2m in the underlying monthly run-rate. The FY23 year-end forecast has reduced to a deficit of £27.2m, with the forecast run rate reducing by £0.7m to an exit run-rate by year end of £1.7m overspend.

The risks to the year-end forecast include delays in recruitment to substantive posts to replace agency staff, agency/locum rates pressures, tertiary care contracts relating to activity volumes, mental health placements and social care packages due to significant price variations, and insufficient headroom to mitigate further cost pressures.

The Financial Recovery Programme (FRP) schemes identified as at M10 are £28m with a risk-adjusted value of £20m which are phased to be delivered over FY23 £3m, FY24 £12m and FY25 £10m. The immediate priority is to deliver the in-year savings target of £3m by the year end. £3.3m savings have been identified by the Care Groups supported by the newly established Programme Management and Delivery Team (PMDT).

Clinical Governance

The number of overdue Serious Incidents (SIs) has improved with 42 open, 27 of which are overdue. Seven have been closed in the last four weeks and anticipating a further six will close in December. SIs outstanding from 2022 have been prioritised in the workstream of the interim Quality and Safety Investigator who commenced employment in November to support the investigation process.

At the end of October, 23 HCS staff completed Mortality Learning Review (MLR) training to assess the care and treatment provided to a person and identify opportunities for learning and improvement. The HCS Mortality Strategy is being drafted and two pilots for MLR have been identified.

Work continues with the care groups to improve the number of out-of-date policies.

HCS has been successful in joining the National Audit Programme which will allow HCS to benchmark against National Institute for Health and Care Excellence (NICE) guidance and NHS organisations. A National Audit Programme for 2024 is being developed.

Electronic Patient Record Implementation

Outstanding issues and concerns continue to be addressed by the Maxims team including targeted training and agreeing delegations to improve clinical staff efficiency.

The new integrated electronic patient record (EPR) is now live on Intensive Care Unit (ITU). This will allow for integration with different audit programmes and the move to a complete paperless clinical documentation process. Although the system is fully integrated with the core EPR (Maxims), there are a few integrations with medical devices that are still outstanding.

EPR core: Additional functionality will be introduced during December 2023 to EPR core.

The electronic prescribing and medicines administration (EPMA) system continues its rollout and has been implemented on ITU. The electronic drug chart is now a continuous record, ensuring a smooth journey for patients that are transferred between inpatient wards. The system is currently being

implementation across outpatients and anticipating completion during Q1 2024.

The BookWise DUO scheduling system is live in Oncology and allows for workflow and booking efficiencies and includes interfacing with Maxims.

A separate programme of work is currently underway to commission a new EPR system for mental health, social care and some community services. Much work has been undertaken within services to determine a specification that will best meet future needs for these services, with a specific focus on service user and carer involvement and potential use / management of their own health information moving forward.

The maternity EPR is being procured and requirements are being gathered with different department stakeholders. Demonstrations will take place in Jan/Feb 2024.

Maternity Improvement Plan

The Maternity Improvement Plan continues, and its performance is managed through weekly meetings chaired by the Medical Director. To-date, Maternity Services have been focused on ensuring it addresses the actions included in the improvement plan, working alongside project management support, ensuring business-as-usual processes are in place and scrutinizing evidence. Recent milestones include a further 13 completed recommendations covering neonatal liaison with tertiary units, guidelines and governance, with a total of 80 (out of 127) recommendations showcasing established business-as-usual processes.

The focus for 2024 will continue on improving culture, multidisciplinary training and competencies.

Acute Medicine Improvement Plan

The Medicine Improvement Programme continues, and its performance is managed through fortnightly meetings chaired by the Chief Operating Officer – Acute Services.

During this time, Medical Services have ensured all recommendations have been tracked with the progress evidenced with project management support. All actions are in progress with 26 recommendations showing evidence to date. Eight of these have made significant progress and four are marked as complete. The focus for 2024 is to ensure that the medical model (staffing) is sufficiently robust to carry through and sustain the recommendations.

The ongoing challenges remains with our current medical model / staffing and the reliance on locums to provide our ward base care which emphasises the need for the focus and efforts to improve this position during 2024. An options appraisal to address this will be presented to the HCS SLT on 29th November.

Recommendations: Government of Jersey (GoJ)

HCS, like all GOJ departments, receives recommendations from a variety of government and audit bodies. In addition to recommendations from clinical and invited reviews, HCS also receives recommendations from the Comptroller and Auditor General (C&AG), Public Accounts Committee (PAC) and Scrutiny Panels.

Following the GoJ CEO's directive to rapidly action and close-down existing Comptroller and Auditor General (C&AG), Public Accounts Committee (PAC) and Scrutiny Panel recommendations, HCS actioned and closed twenty-three outstanding recommendations from the C&AG and PAC, twenty-four remain. Work is now underway to action as many of the sixty open Scrutiny recommendations before year end.

In total, HCS currently has eighty-four open recommendations from three bodies mentioned previously.

New Healthcare Facilities (NHF)

In line with developing the acute facility at Overdale, a series of Clinical User Groups are planned across December and January to ensure good clinical input and engagement informs the design.

Proposed clinical adjacencies in the acute building have been reviewed at a senior level, with feedback received which will be incorporated in the next iteration of plans.

Whilst the acute functional brief is the priority, other briefs (Ambulatory, Health Village and the Overarching Functional brief) are developed and have been shared with senior clinicians and leaders for review and feedback. Once they have had an opportunity to review the acute site functional brief, this will be shared more widely across HCS.

A phased schedule of demolition at Overdale is planned, commencing with the buildings that have been empty for the longest period on the southwest of the site. The contractors and the NHF team are liaising closely and regularly with the Ward Sister on Samare Ward (until relocation in early 2024) and the staff of the neighbouring crematorium, to ensure there is no detrimental impact as demolition proceeds.

Cultural Change Programme

A culture change plan has been developed for 2024 and considered by the SLT which delivers a range of planned and deliberate, existing and new cultural interventions including Civility Saves Lives, Restorative Just Learning and enabling staff through a coaching style of leadership to encourage improvement and enable teams to solve problems for themselves.

Ways to measure culture change and readiness for improvement at care group and service/team levels are being developed. Listening events have continued for all staff through HCS Team Talks and Schwartz Rounds. The reward and recognition of the achievements for HCS staff was celebrated at a dedicated Our Stars 2023 evening event which was attended by more than 200 HCS staff alongside the Chief Officer for HCS and Deputy Wilson, Health Minister; 21 awards were presented.

Waiting Lists

The outpatient waiting list volume decreased by 2% for the first time since the implementation of the electronic patient record in May 2023 from 13,398 patients to 13,162 patients (-236). Key pressures remain in the same areas as the previous board report (Ophthalmology, Ear Nose and Throat (ENT), Dermatology and Trauma and Orthopaedics). An outsourcing contract has now been awarded for Ophthalmology services in support of the HCS department.

The percentage of patients waiting greater than 90 days for their first outpatient appointment increased from 45.8% to 47.4%. This is despite a reduction in community services for the same metric (54% to 51.7%) which is being driven by the commissioned community dental service. To date the community dental waiting list volume has decreased from 1,826 patients to 653 patients (-1173 or –64.23%).

The Diagnostic waiting list volume has decreased from 2,548 patients to 2,309 (-9%). On the 6 October 2023 the endoscopy insourcing project went live which is driving this reduction; the endoscopy waiting list has decreased by 225 patients in the first weekends since implementation. An additional four weekends activity will be delivered in 2023, followed by a further eight weekends in Q1 2024.

In addition to the above, the MRI recovery plan continues to deliver. At the start of the programme the waiting list had peaked at 1,111 patients on the 06/09/2023. This has reduced to 344 patients as at the 22/11/2023, a reduction of 767 patients / 69%. In relation to waiting time this had reduced from 53 weeks down to 11 weeks for a routine appointment.

The recovery plan remains on trajectory to reduce the routine wait to 6 weeks by the end of the project

(22/12/2023).

The elective inpatient waiting list increased marginally from 2,724 patients to 2,749 patients. Elective day case activity increased from 529 operations to 719 operations but elective admissions at 160 for October have not returned to the same levels completed prior to the new EPR going live (i.e., > 200 per month). Protracted delays to surgery remain in the same key areas, lower limb operations and upper gastrointestinal surgery.

Within mental health services, waiting lists for attention deficit hyperactive disorder (ADHD), specialist diagnostic services and for psychological therapies remain a serious key concern. The Mental Health Services Leadership Team continue to seek to reduce these waiting times, in particular through the increase of clinical capacity within these services. Recruitment challenges are a key factor in making improvements.

Workforce

A priority focus continues to be on the recruitment of substantive employees with agency and locum usage remaining high. This work will be covered in detail in the Board's workforce report but in summary the vacancy rate has dropped in the last two months from 18% to 16% despite a further increase in the number of funded establishment posts. This equates to 478 whole time equivalents (WTE) vacancies out of a funded establishment of 2902 WTE.

In the last 12 months there has been an increase of 224 WTE staff in post across the department with an increase of 49 WTE doctors and 46 WTE nurses. Over the last month there has been a reduction in the number of agency workers covering vacancies in HCS of 10 WTE.

Freedom to Speak Up Guardian (FTSU)

It is encouraging to see this report as part of the board agenda and how staff are using this new and vital role as part of the cultural change programme in HCS.

Quality

October data demonstrates notable trends in key areas. Although complaints have risen from 29 in September to 42 in October, this is in line with trend data from previous years. There has been a commendable 18% reduction within the month in unresolved complaints, dropping from 85% to 67%.

The incidence of category 2 pressure damage per 1000 bed days has decreased from 2.25 to 1.54, indicating positive outcomes from pressure damage related documentation and audits.

Clinical audits focusing on food and nutrition showcase a 10% increase in compliance, with some areas exceeding 90% adherence to the Malnutrition Universal Scoring Tool (MUST).

Falls have decreased from 6.4 to 5.8 per thousand bed days, with a drop from 54 falls in September to 42 in October. Of these, 2 resulted in moderate harm,1 reported as a supported fall to the floor with the remaining reported as low or no harm.

Infection Prevention and Control (IPAC) continues to demonstrate low levels of infection with targeted work on improving vaccination uptake amongst staff.

2024 Priorities

The 2024 HCS priorities will be considered at the Board workshop on 5th December and presented to the January board meeting for approval. The following are included,

1. The key performance indicators (KPIs) to be used in 2024 to ensure that data is transparent, understandable and drives improved performance.
2. The Board Assurance Framework to align with ministerial and organisational priorities and associated risks.

Staff engagement and achievements

- Colleagues braved extremely difficult conditions (Storm Ciaran) to ensure they were at work to care for our patients.
- HCS celebrated Occupational Therapy (OT) week, putting a spotlight on our team of OTs.
- 'Together, A Cancer Strategy for Jersey' was launched by Dr Elizabet dos Santos (Consultant) and the Cancer Strategy Steering Group.
- HCS colleagues fundraised for Children in Need with a treadmill challenge and cake sale.
- The HCS Festive Prize Draw was launched which looks to recognize staff achievements from 2023. So far, 350+ nominations have been made.
- The Safeguarding Adult Team (SAT) took part in the Adult Safeguarding week, helping to educate colleagues and Islanders to spot the signs of financial abuse and neglect.
- HCS Our Stars awards, recognizing the achievements of many HCS colleagues, taken from over 400 recommendations, with 21 awards being presented.
- A preventative cardiology nurse has been appointed.
- Colleagues celebrated the World Antimicrobial (resistance) Awareness week.
- The Help2Quit, Safeguarding and Screening Teams took part in Public Health's WellFest event.
- The Maternity team celebrated Maternity Support Worker Day. Members of staff received a gift from the Royal College of Midwives.
- Seven colleagues completed the first mindfulness for stress course.
- The Podiatry team launched the 'Lost Soles' project, which saw them volunteer to give care to homeless persons at Aztec House.
- Jocelyn O'Connell, Nursing Manager, was a finalist in the 'Angel of the Year' category of the 'Pride of Jersey' awards.
- Staff achievement across HCS continues to be celebrated through the Wow Wednesday newsletter.

4. Recommendation

The Board is asked to note the report.

END OF REPORT

Health and Community Services

Quality and Performance Report October 2023

Government of Jersey

INTRODUCTION

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

PURPOSE

The Quality and Performance Report (QPR) is the reporting tool providing assurance and evidence to the committee that care groups are meeting quality and performance across the full range of HCS services and activities. Indicators are chosen that are considered important and robust to enable monitoring against the organisation's objectives. Where performance is below standards, the committee will ensure that robust recovery plans are developed and implemented.

BACKGROUND

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

SPONSORS:

Interim Chief Nurse - Jessie Marshall

Medical Director - Patrick Armstrong

Chief Operating Officer – Acute Services - Claire Thompson

Director Mental Health & Adult Social Care - Andy Weir

DATA

HCS Informatics

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EXECUTIVE SUMMARY

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

General & Acute Performance

Acute Hospital Services: no significant change in ED attendances in October or emergency admissions. Improvement is noted on the commenced treatment metric across minor & major areas of ED care. Planned care saw increases both in outpatient and inpatient activity due to elements of waiting list recovery plans and increased scheduling especially to day case activity. Consequently, all areas of the new outpatient waiting list reduced (community, acute & diagnostic) specifically due to waiting list recovery plans delivering change in month. The TCI waiting list increased slightly due to conversion to surgery post outpatient appointment.

Mental Health & Social Care Performance

Performance against our KPIs within mental health and adult social care remain relatively consistent this month. The key issues continue to relate to waiting times for specialist diagnostic assessment services and treatment within psychological therapies, and the care group continues to seek to address this through additional capacity to meet need. It is positive to see the sustained achievement of the face to face contact within 72 hours of discharge KPI, as this is a key patient safety metric within mental health services. Whilst the Crisis & Assessment Team are not quite achieving the 85% access targets each month, much of this relates to patient choice and the significantly improved position overall following the introduction of the new community model from November 2022 (with a year to date position of 86% of crisis assessments and 82% of routine assessments being completed within the target time frames).

Quality & Safety

October saw an improvement in several quality metrics with none triggering an alert and all within expected measures.

Whilst the number of complaints has increased from 29 received in September to 42 received in October, October has seen a significant improvement, with an overall reduction of 18% of the number of open complaints that's have not been resolved in the required response time reducing from 85% to 67%.

There has been a decrease in the numbers of patients suffering from category 2 pressure damage from 2.25 to 1.54

DEMAND

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

Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	On Month	YoY
General and Acute Outpatient Referrals	3586	4104	3332	3837	3622	4812	3731	3789	4297	4018	3881	3982	4489		40458	13%	25%
General and Acute Outpatient Referrals - Under 18	302	365	411	348	432	414	308	305	435	371	313	387	428		3741	11%	42%
Additions to Inpatient Waiting List	535	581	451	455	495	571	468	427	273	262	222	367	513		4053	40%	-4%
Referrals to Mental Health Crisis Team	ND	52	91	87	83	90	91	93	113	104	100	93	83		937	-11%	NA
Referrals to Mental Health Assessment Team	ND	139	201	237	215	272	187	229	249	234	321	229	251		2424	10%	NA
Referrals to Memory Service	21	33	30	57	43	56	43	29	27	27	40	28	7		357	-75%	-67%
Referrals to Jersey Talking Therapies	112	113	74	104	98	134	109	94	105	90	110	120	125		1089	4%	12%

ACTIVITY

Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	On Month	YoY
General and Acute Outpatient Attendances	19057	21502	16596	19916	19315	21533	16712	17425	16893	15592	16171	16961	18388		178906	8%	-4%
Elective Admissions	240	230	163	213	233	335	315	265	166	155	132	138	160		2112	16%	-33%
Elective Day Cases	685	700	532	629	615	701	428	583	549	513	545	529	719		5811	36%	5%
Elective Regular Day Admissions	908	923	903	952	884	1064	932	1087	1072	1029	1046	1002	1050		10118	5%	16%
Ward Attenders and Ambulatory Emergency Care (AEC) non-elective day admissions	274	277	268	316	240	245	180	162	160	150	147	144	105		1849	-27%	-62%
Emergency Department Attendances	3479	3394	3325	3270	2982	3501	3345	3547	3762	3671	3714	3569	3309		34670	-7%	-5%
Emergency Admissions	583	588	571	579	502	571	555	625	591	553	544	542	556		5618	3%	-5%
Admissions to Adult Mental Health unit (Orchard House)	14	11	8	16	13	15	10	9	12	15	14	13	12		129	-8%	-14%
Admissions to Older Adult Mental Health units (Beech/Cedar wards)	1	0	1	1	2	1	2	1	0	3	3	2	1		16	-50%	0%
Maternity Deliveries	63	70	63	77	60	68	59	68	53	77	71	64	60		657	-6%	-5%

WAITING LISTS

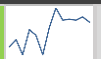
Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	On Month	YoY
Outpatient 1st Appointment Waiting List	9394	9049	9245	9036	8571	9044	9296	9814	10917	12668	13077	13398	13162		13162	-2%	40%
Outpatient 1st Appointment Waiting List - Acute	7265	7069	7247	7232	6807	7413	7860	8399	9875	11388	11793	12099	11926		11926	-1%	64%
Outpatient 1st Appointment Waiting List - Community	2129	1980	1998	1804	1764	1631	1436	1415	1042	1280	1284	1299	1236		1236	-5%	-42%
Diagnostics Waiting List	1022	1027	992	955	908	1030	1025	1027	971	2400	2489	2548	2309		2309	-9%	126%
Elective Waiting List	2157	2186	2293	2409	2424	2385	2434	2375	2699	2730	2651	2724	2749		2749	1%	27%
Elective Waiting List - Under 18	100	84	87	90	106	101	91	93	100	86	71	79	79		79	0%	-21%
Jersey Talking Therapies Assessment Waiting List	143	150	145	138	117	159	167	147	133	97	66	121	105		105	-13%	-27%

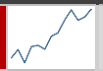
QUALITY AND PERFORMANCE SCORECARD

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

CATEGORY	INDICATOR	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
GENERAL AND ACUTE WAITING LISTS																	
Outpatients	% patients waiting over 90 days for 1st outpatient appointment	46.2%	44.0%	43.5%	42.3%	42.1%	38.1%	38.1%	40.5%	40.2%	41.8%	42.5%	45.8%	47.4%		47.4%	<35%
	% patients waiting over 90 days for 1st OP appointment - Acute	35.2%	33.0%	34.2%	34.5%	35.6%	30.6%	32.2%	35.0%	35.8%	39.4%	40.8%	44.9%	47.0%		47.0%	<35%
	% patients waiting over 90 days for 1st OP appointment - Community	83.6%	83.1%	77.2%	73.7%	67.3%	71.9%	70.0%	73.4%	81.7%	63.0%	58.3%	54.0%	51.7%		51.7%	<35%
Diagnostics	% patients waiting over 90 days for diagnostics	48.1%	49.8%	53.6%	55.4%	58.8%	49.6%	49.2%	50.6%	69.8%	70.8%	70.2%	69.2%	68.9%		68.9%	<35%
Inpatients	% patients waiting over 90 days for elective admissions	53.3%	49.6%	50.0%	54.5%	57.8%	56.1%	55.1%	55.7%	58.1%	56.4%	58.1%	59.0%	58.9%		58.9%	<35%
PLANNED (ELECTIVE) CARE																	
Outpatients	New to follow-up ratio	2.6	2.7	2.8	2.8	2.8	2.9	2.8	2.9	2.9	2.9	2.8	2.6	2.5		2.8	2.0
	Outpatient Did Not Attend (DNA) Rate	7.6%	8.2%	7.8%	7.5%	6.8%	6.9%	7.0%	7.3%	11.7%	12.6%	12.3%	12.9%	11.3%		9.6%	<8%
Elective Inpatients	Acute elective Length of Stay (LOS)	2.5	2.6	2.3	1.8	1.7	2.1	2.3	2.2	2.5	3.1	3.6	2.8	3.4		2.5	<3
	% of all elective admissions that were day cases	79%	76%	81%	80%	79%	78%	75%	76%	76%	75%	79%	75%	75%		76.8%	>80%
	% of all elective admissions that were private	25%	25%	30%	30%	24%	29%	28%	30%	31%	27%	24%	28%	28%		27.9%	>32% and <34%
Theatres	Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations)	77.9%	75.0%	69.1%	74.0%	73.1%	73.6%	78.4%	72.9%	63.4%	64.3%	63.4%	64.2%	66.9%		68.5%	>85%
	Turnaround time as % of total session time	13.1%	14.9%	14.7%	18.3%	19.0%	16.9%	14.7%	14.3%	10.4%	12.1%	10.7%	12.8%	12.2%		13.8%	<15%

CATEGORY	INDICATOR	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE																	
Emergency Department (ED)	Median Time from Arrival to Triage	9	10	10	11	11	10	12	14	26	17	16	17	16		15	<11
	% Triaged within Target - Minor	59%	53%	51%	51%	52%	54%	49%	43%	26%	43%	46%	44%	46%		45%	>=90%
	% Triaged within Target - Major	67%	63%	61%	60%	60%	64%	58%	56%	31%	42%	44%	46%	43%		50%	>=90%
	Median Time from Arrival to commencing Treatment	43	39	40	38	41	38	44	41	60	40	37	33	32		40	<75
	% Commenced Treatment within Target - Minor	83%	86%	84%	83%	86%	85%	82%	84%	78%	89%	89%	94%	94%		86%	>=70%
	% Commenced Treatment within Target - Major	63%	61%	61%	62%	64%	66%	63%	66%	53%	71%	70%	73%	73%		66%	>=70%
	Median Total Stay in ED (mins)	153	148	160	158	148	149	160	156	173	149	146	146	153		154	<189
	Total patients in ED > 10 hours	12	27	69	45	19	55	39	54	58	36	76	72	51		505	<1
	ED conversion rate	16%	17%	17%	17%	16%	16%	16%	16%	15%	14%	14%	15%	16%		15%	<20%
Emergency Inpatients	Non-elective acute Length of Stay (LOS)	6.0	6.1	7.4	7.1	7.0	7.1	6.6	6.5	6.1	6.8	7.3	8.8	8.2		7.1	<10
	% Emergency admissions with 0 Length of Stay (Same day discharge)	11%	8%	7%	7%	9%	8%	8%	10%	14%	12%	15%	13%	13%		11%	<17%
	Acute bed occupancy at midnight (Elective & Non-Elective)	95%	97%	94%	97%	90%	95%	95%	89%	87%	89%	87%	92%	89%		91%	<85%
	% of Inpatients discharged between 8am and noon	10%	11%	11%	13%	11%	12%	11%	13%	13%	11%	13%	11%	14%		12%	>=15%
	Average daily number of patients Medically Fit For Discharge (MFFD)	27.0	24.0	31.1	23.2	23.9	31.1	24.2	23.2	ND	ND	ND	57.8	47.7		33.0	<30
	Total Bed Days Medically Fit For Discharge	811	721	932	718	669	932	702	579	ND	ND	ND	1733	1480		6813	<910
	Total Bed Days Delayed Transfer Of Care (DTOC)	578	466	622	442	511	628	467	412	ND	ND	ND	ND	919		3379	NA
	Rate of Emergency readmission within 30 days of a previous inpatient discharge	12%	11%	10%	10%	10%	9%	10%	13%	11%	8%	12%	10%	11%		10%	<10%

CATEGORY	INDICATOR	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
MENTAL HEALTH																	
Jersey Talking Therapies (JTT)	% of clients waiting for assessment who have waited over 90 days	0.7%	1.3%	0.0%	2.2%	1.7%	0.0%	2.4%	4.1%	3.0%	3.1%	3.0%	3.3%	2.9%		2%	<5%
	% of clients who started treatment in period who waited over 18 weeks	59%	64%	28%	61%	38%	47%	20%	38%	35%	59%	32%	45%	49%		45%	<5%
	JTT Average waiting time to treatment (Days)	196	170	102	165	130	141	96	134	154	162	124	153	166		142	<=177
	% of eligible cases that have completed treatment and were moved to recovery	54%	42%	62%	67%	44%	59%	64%	54%	91%	63%	38%	32%	65%		56%	>50%
	% of eligible cases that have shown reliable improvement	92%	71%	85%	78%	76%	71%	68%	77%	91%	75%	50%	77%	76%		74%	>75%
Community Mental Health Services	Memory Service - Average Time to assessment (Days)	180	153	152	126	137	110	126	152	177	182	188	210	190		160	<138
	% of referrals to Mental Health Crisis Team assessed in period within 4 hours	ND	70.0%	77.1%	84.1%	93.0%	83.3%	87.3%	86.7%	98.5%	84%	81%	88%	77%		86%	>85%
	% of referrals to Mental Health Assessment Team assessed in period within 10 working days	ND	96.8%	88.3%	83.8%	77.4%	80.7%	89.6%	86.0%	82.3%	77%	83%	78%	82%		82%	>85%
	% of Adult Acute discharges with a face to face contact from an appropriate Mental Health professional within 3 days	ND	57%	64%	100%	67%	56%	100%	92%	89%	84%	94%	87%	92%		85%	>80%
	% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days	ND	60%	50%	67%	0%	100%	80%	83%	100%	0%	100%	75%	100%		81%	>80%
	Community Mental Health Team did not attend (DNA) rate	7.4%	4.8%	6.6%	6.0%	5.3%	6.0%	7.1%	6.4%	7.0%	5.8%	7.0%	6.3%	6.6%		6%	<10%
	Adult Acute Admissions per 100,000 population - Rolling 12 month	241	234	224	229	226	233	229	221	219	220	209	205	202		202	<255
	Adult acute admissions under the Mental Health Law as a % of all admissions	64%	36%	50%	25%	31%	47%	40%	11%	50%	47%	43%	69%	25%		40%	<37%
Inpatient Mental Health	Adult acute bed occupancy at midnight (including leave)	92%	93%	91%	95%	88%	94%	99%	93%	89%	84%	86%	86%	84%		90%	<88%
	Older Adult Admissions per 100,000 population - Rolling 12 month	357	376	380	369	379	363	342	362	361	384	353	377	406		406	<475
	Older adult acute bed occupancy (including leave)	98%	91%	98%	99%	99%	99%	96%	89%	86%	93%	88%	85%	89%		92%	<85%
	Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health	20	16	14	15	14	13	13	15	ND	ND	ND	11	9		12.77	<13

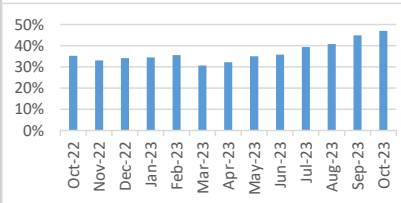
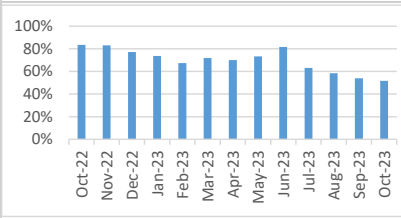
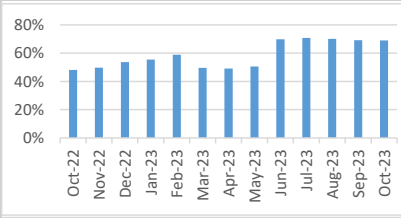
CATEGORY	INDICATOR	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
SOCIAL CARE																	
Learning Disability	Percentage of clients with a Physical Health check in the past year	67%	69%	66%	69%	69%	69%	71%	72%	74%	76%	74%	74%	76%		72%	>80%
Adult Social Care Team (ASCT)	Percentage of Assessments completed and authorised within 3 weeks (ASCT)	93%	88%	90%	70%	83%	80%	73%	53%	86%	85%	84%	86%	93%		79%	>=80%
	Percentage of new Support Plans reviewed within 6 weeks (ASCT)	33%	63%	45%	40%	65%	71%	50%	47%	54%	65%	66%	62%	65%		59%	>=80%

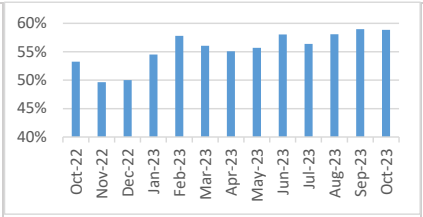
CATEGORY	INDICATOR	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
WOMEN'S AND CHILDREN'S SERVICES																	
Children	Was Not Brought Rate	10.5%	11.6%	10.9%	9.5%	8.1%	8.5%	10.6%	10.9%	19.8%	19.7%	20.4%	19.1%	13.5%		14.2%	<=10%
	Average length of stay on Robin Ward	1.62	2.21	1.85	1.35	1.56	2.93	1.73	2.74	1.50	1.38	1.39	1.44	1.43		1.8	<=1.65
	% deliveries home birth (Planned & Unscheduled)	4.8%	14.3%	3.2%	7.8%	5.0%	11.8%	8.5%	4.4%	7.5%	2.6%	5.6%	3.1%	5.0%		6.1%	NA
	% Spontaneous vaginal births (including home births and breech vaginal deliveries)	38.7%	44.3%	28.3%	44.0%	50.0%	46.3%	33.9%	23.9%	39.6%	35.2%	32.4%	34.4%	36.4%		37.5%	NA
	% Instrumental deliveries	12.7%	4.3%	9.5%	9.1%	16.7%	7.4%	15.3%	11.8%	9.4%	6.5%	16.9%	6.3%	10.0%		10.8%	NA
	% Emergency caesarean section births	17.7%	15.7%	25.0%	25.3%	16.7%	16.4%	20.3%	28.4%	9.4%	31.0%	22.5%	15.6%	32.7%		22.1%	NA
	% Elective caesarean section births	24.2%	28.6%	26.7%	29.3%	16.7%	22.4%	23.7%	26.9%	26.4%	23.9%	22.5%	21.9%	23.6%		23.8%	NA
Maternity	% of women that have an induced labour	25.4%	20.0%	38.1%	14.3%	26.7%	20.6%	23.7%	35.3%	22.6%	19.5%	28.2%	28.1%	18.3%		23.6%	<=27.57%
	Number of stillbirths	1	0	0	0	0	0	0	0	0	0	0	0	0		0	0
	Rate of Vaginal Birth After Caesarean (VBAC)	11.1%	0.0%	9.1%	5.0%	28.6%	14.3%	28.6%	16.7%	0.0%	20.0%	37.5%	25.0%	11.1%		16.5%	>15%
	% primary postpartum haemorrhage >= 1500ml	6.3%	2.9%	4.8%	5.2%	3.3%	4.4%	5.1%	14.7%	3.8%	3.9%	2.8%	4.7%	6.7%		5.5%	<=6.75%
	% 3rd & 4th degree tears – normal birth	0.0%	2.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	0.0%	0.0%	2.9%	9.1%		1.4%	<2.5%
	% of births less than 37 weeks	7.9%	10.0%	12.7%	13.0%	10.0%	13.2%	3.4%	10.3%	0.0%	7.8%	2.8%	3.1%	13.3%		7.9%	<=6.85%
	% births requiring Jersey Neonatal Unit admission	11.1%	8.6%	11.1%	13.0%	10.0%	17.6%	5.1%	8.8%	3.8%	18.2%	11.3%	4.7%	16.7%		11.3%	<=5.05%
	% of babies that have APGAR score below 7 at 5 mins	0.0%	5.7%	1.7%	0.0%	0.0%	1.5%	1.7%	3.0%	0.0%	4.2%	1.4%	1.6%	5.5%		1.9%	<=1.3%
	Average length of stay on maternity ward	2.15	2.44	2.20	1.86	2.07	2.21	2.15	2.33	1.43	1.74	1.45	1.58	1.61		1.82	<=2.28

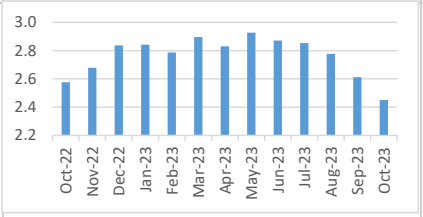
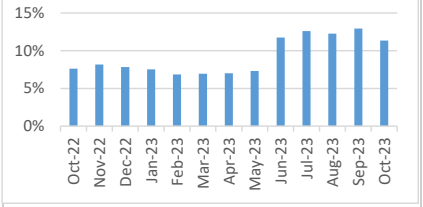
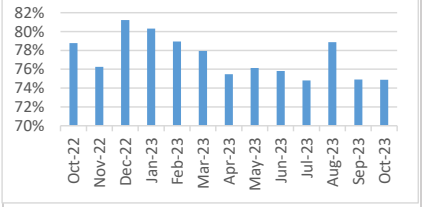
CATEGORY	INDICATOR		Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
QUALITY AND SAFETY																		
Infection Control	MRSA Bacteraemia	Hosp	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
	MSSA Bacteraemia	Hosp	0	1	1	0	0	1	1	1	0	0	0	0	0		3	0
	E-Coli Bacteraemia	Hosp	0	1	0	0	0	0	1	1	0	1	0	1	0		4	0
	Klebsiella Bacteraemia	Hosp	1	0	0	0	1	1	0	0	0	0	0	0	0		2	0
	Pseudomonas Bacteraemia	Hosp	0	0	1	0	0	0	0	1	1	0	0	0	1		3	0
	C-Diff Cases	Hosp	2	0	0	1	2	1	1	2	1	1	0	1	2		12	1
Safety Events	Number of falls resulting in harm (low/moderate/severe) per 1,000 bed days		1.2	3.1	3.0	2.5	2.6	3.1	3.0	4.4	4.1	2.9	4.7	2.8	3.8		3	NA
	Number of falls per 1,000 bed days		4.8	6.0	8.2	6.3	6.4	6.6	6.0	7.3	8.5	7.5	10.0	6.4	5.8		7	<6
	Number of medication errors across HCS resulting in harm per 1000 bed days		0.2	1.6	0.9	1.3	1.0	1.0	0.5	0.7	0.7	0.5	1.4	1.4	0.9		1.0	<0.40
	Number of serious incidents		1	2	1	0	2	3	4	2	9	5	4	2	0		31	NA
VTE	% of adult inpatients who have had a VTE risk assessment within 24 hours of admission		ND	ND	ND	ND	ND	ND	ND	ND	11%	12%	32%	31%	24%		22%	>95%
Pressure Ulcers	Number of pressure ulcers acquired as an inpatient per 1,000 bed days		3.19	2.74	1.74	2.50	2.60	1.39	1.94	1.65	2.70	1.71	1.40	2.96	2.40		2.12	<2.87
	Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days		2.13	1.64	1.39	1.83	1.80	1.04	1.77	0.92	2.34	1.37	1.22	2.26	1.54		1.6	<1.96
	Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days		0.71	1.10	0.35	0.50	0.80	0.35	0.18	0.55	0.18	0.00	0.00	0.17	0.17		0.28	<0.60
Feedback	Number of comments received		18	29	25	15	8	17	12	27	25	35	22	33	48		242	NA
	Number of compliments received		69	53	96	76	95	60	70	58	63	83	49	182	96		832	NA
	Number of complaints received		47	53	29	55	43	34	35	24	43	36	42	28	40		380	NA
	% of all complaints closed in the period which were responded to within the target		ND	54%	21%	31%	14%	21%	37%	21%	6%	18%	20%	20%	21%		20.0%	>40%

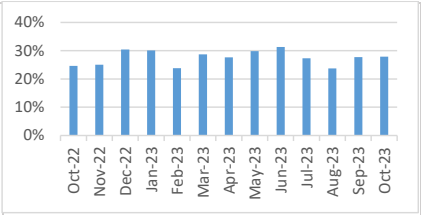
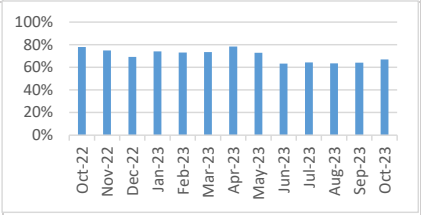
EXCEPTION REPORTS

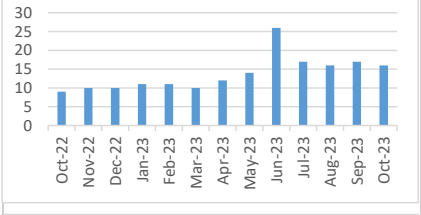
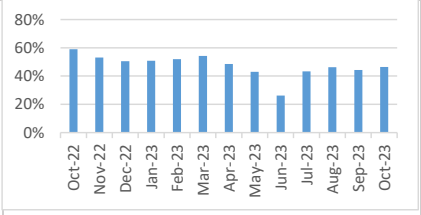
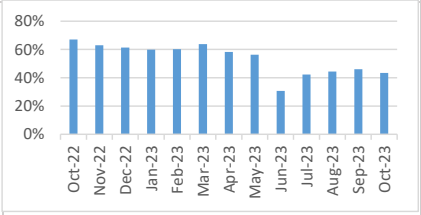
GENERAL AND ACUTE WAITING LISTS

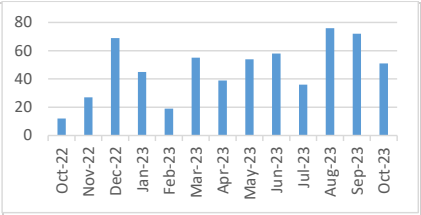
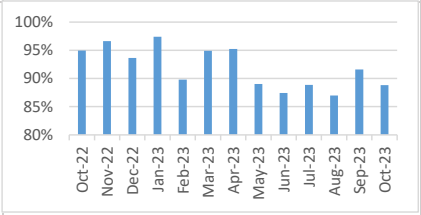
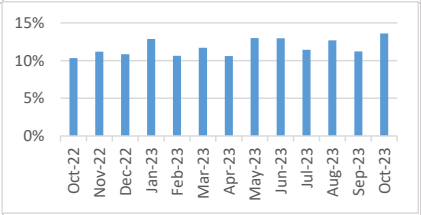
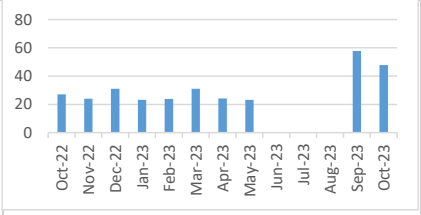
INDICATOR	13-MONTH GRAPH	COMMENTARY & ACTION PLAN	TRIGGER & OWNER
% patients waiting over 90 days for 1st outpatient appointment		This indicator is made up of two component parts (Acute and Community) which have their own commentary and action plans.	>35% Chief Operating Officer - Acute Services
% patients waiting over 90 days for 1st OP appointment - Acute		Ophthalmology, Clinical Genetics and Trauma and Orthopaedics remain the greatest outlier in the relation to patients waiting > 90 days. In addition to this the Government of Jersey on behalf of Health and Community Services are currently engaging with external quality assured providers to assist in supporting the identification of a suitable outsourced delivery model that could meet the specific requirements of Jersey patients. The specific clinical outsourcing service will provide additional capacity for a time limited period aiming to reduce the backlog of patients in Ophthalmology. Clinical Genetics: Awaiting decision from ELT if clinical genetics remains as an unfunded service and what the criteria for inclusion is. Dermatology continues to be a challenge to recruit to. There has been additional activity to support longest waiters/urgents and soon.	>35% Chief Operating Officer - Acute Services
% patients waiting over 90 days for 1st OP appointment - Community		Work continues to reduce the waiting times across therapies and community dental, the commissioned dental scheme has contributed to a huge drop in the community dental waiting list. Issues with recruitment of staff in therapies is accounting for a slower progression in these departments.	>35% Chief Operating Officer - Acute Services
% patients waiting over 90 days for diagnostics		Endoscopy remains the greatest outlier in relation to this metric. Xyla Elective Care have been appointed as a quality assured provider delivery time limited additional capacity to the endoscopy unit. The mobilisation period commenced in August with the first activity on track to commence on the weekend 07th-08th October. The diagnostic waiting list is continuing to be validated post implementation of the new EPR. The diagnostic PTL included a number of patients on surveillance pathway.	>35% Chief Operating Officer - Acute Services

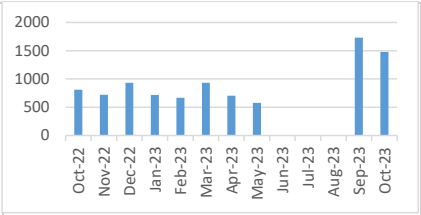
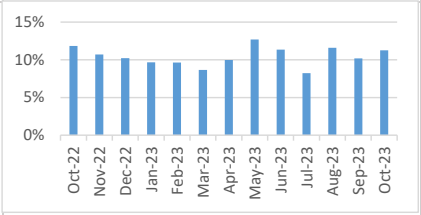
% patients waiting over 90 days for elective admissions		HCS remains challenged across a number of specialties including Trauma and Orthopaedics, General Surgery, Ophthalmology, ENT and Gynaecology in relation to the % of patients waiting > 90 days. HCS is funded to complete additional ad-hoc activity through a variety of initiatives across all specialties. Extra sessions have taken place in Urology, General Surgery and Ophthalmology as a part of waiting list initiative.	>35% Chief Operating Officer - Acute Services

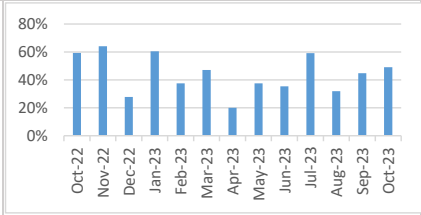
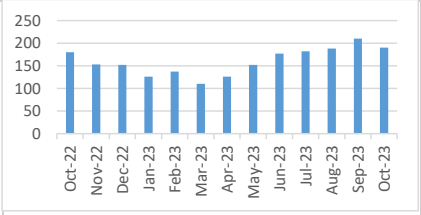
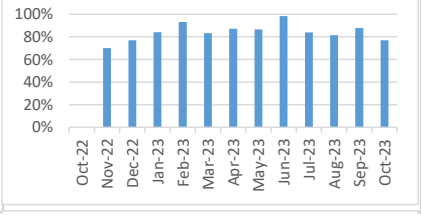
PLANNED (ELECTIVE) CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
New to follow-up ratio		Improving trend is observed. Actions to address unwarranted variation in New to follow up rates is a part of the clinical productivity FRP workstream.	> 2.0 Chief Operating Officer - Acute Services
Outpatient Did Not Attend (DNA) Rate		The DNA rate has continued to grow since the implementation of IMS Maxims and the move to Enid Quenault Healthcare Facilities. Text message reminders have been restarted and many islanders are now aware of the EQ Health centre, a reduciton in DNA's is noted and will continue to be observed as part of the clinical productivity OPA FRP workstream.	>8% Chief Operating Officer - Acute Services
% of all elective admissions that were day cases		Cases that can be converted to day cases to assist with our elective bed management is part of elective planning, 642 process and also a systematic review of day case activity is inlcuded in the 2024 clinical productivity workstream. An increase in month is noted but the % metric requires review also to ensure is driving efficiency and clinical effectiveness.	<80% Chief Operating Officer - Acute Services

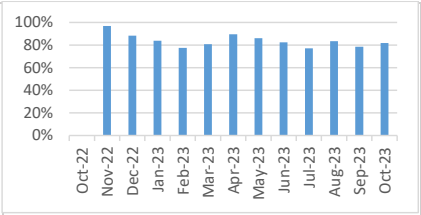
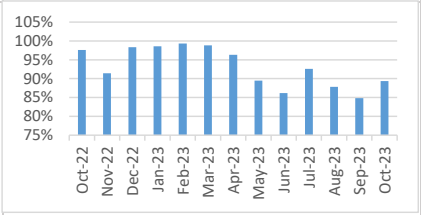
% of all elective admissions that were private		Delivery of 28% of private patient elective activity compared to 27% in previous period. This is subjected to the limitations of separate listing, and the listing of private patients is subject to the requirement of the individual clinicians.	<32% or >34% Chief Operating Officer - Acute Services
Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations)		The 6-4-2 meeting continues to check and challenge the next 2/52 planned operating lists utilising historic data in relation to operating length. Data quality continues to be an issue, particularly with the adjustment to the new EPR . Time stamps are now working really well and the information being filled. The report is being used by the theatre leadership to support. A breakdown of private and public theatre utilisation is being prepared to inform actions.	<85% Chief Operating Officer - Acute Services

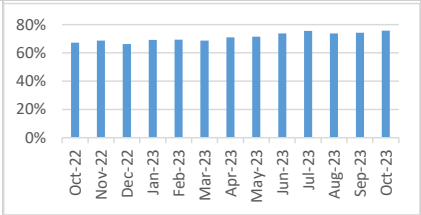
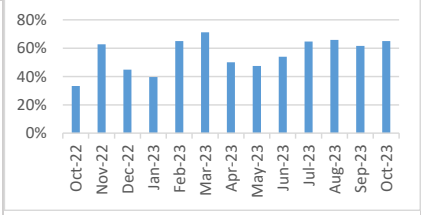
UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
Median Time from Arrival to Triage		Time to Triage has remained static due to staffing and training issues. Practice development nurse who has been appointed will be addressing this as part of their portfolio.	>10 Chief Operating Officer - Acute Services
% Triaged within Target - Minor		Practice development nurse who has been appointed will be addressing this as part of their portfolio.	90% Chief Operating Officer - Acute Services
% Triaged within Target - Major		Majors patients are seen on arrival or within 10 minutes however nurses completing triage also start with IV cannula and blood tests as well as doing any urgent clinical interventions that are necessary, thus entering clinical triage data on MAXIMS retrospectively. Therefore the data has not been recorded correctly, to mitigate this we are looking at developoing a more accurate quality indicators to reflect current patient care in the department	90% Chief Operating Officer - Acute Services

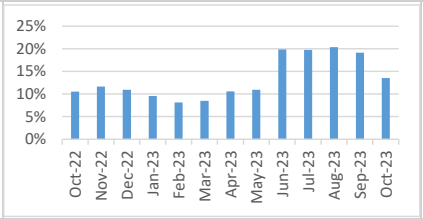
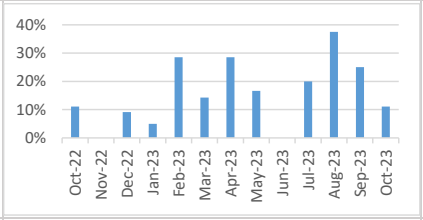
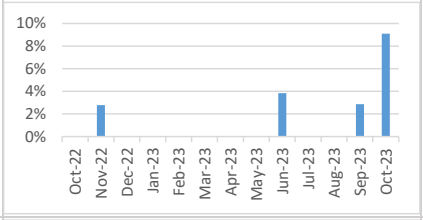
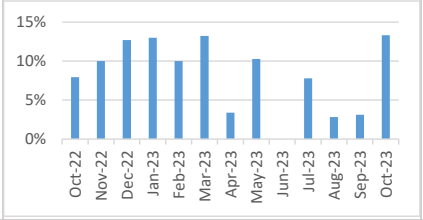
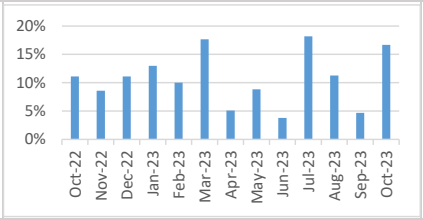
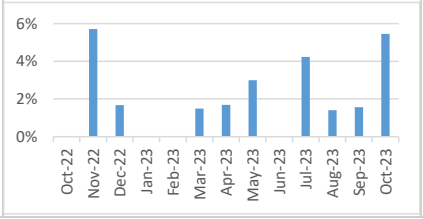
Total patients in ED > 10 hours		This data contains data quality issues as not all notes are recorded in real time. Some patient data will be accurate and are due to awaiting an inpatient bed, however this is compounded by the high number of delayed discharge patients. Discharge workstreams are looking to address the high number of delayed discharges to resolve the data quality issue we are looking at flow in the hospital as well as ensuring appropriate staffing (nursing and medical) to allow contemporaneous discharges on MAXIMs	>0 Chief Operating Officer - Acute Services
Acute bed occupancy at midnight (Elective & Non-Elective)		A reduction in hospital occupancy has been noted in October, through the patient flow improvement workstream length of stay efficiency projects continue to be implemented which improves hospital occupancy. Services such as Same Day Emergency Care (SDEC) previously known as Ambulatory Emergency Care enable patients to be treated same day rather than requiring an inpatient stay.	>85% Chief Operating Officer - Acute Services
% of Inpatients discharged between 8am and noon		An improvement in the discharges before midday has been noted, the golden patient initiative has been relaunched to increase discharges before midday aligned to the SAFER care bundle	15% Chief Operating Officer - Acute Services
Average daily number of patients Medically Fit For Discharge (MFFD)		An improvement in the number of medically fit for discharge patients is noted however MFFD patients remain considerably higher than pre-pandemic. It should be noted that a significant increase is noted in comparison to Q1 & Q2 due to a change in system functionality as the hospital moved to a new IT system. Work is ongoing to reflect an accurate position in the Quality Performance Report.	>30 Chief Operating Officer - Acute Services

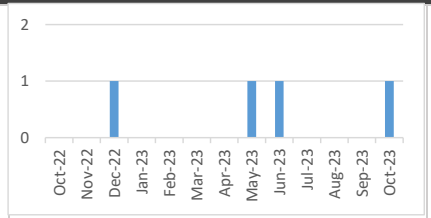
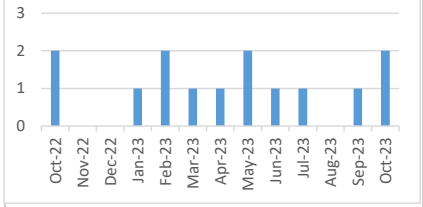
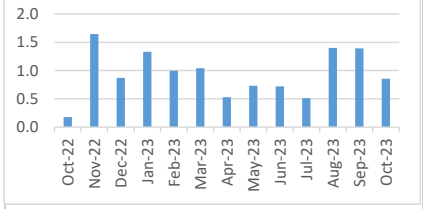
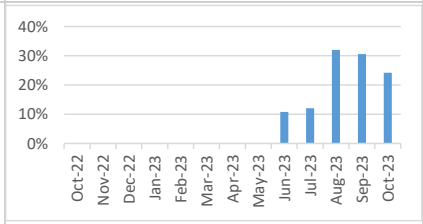
Total Bed Days Medically Fit For Discharge		An improvement in the number of medically fit for discharge bed days is noted however MFFD patients remain considerably higher than pre-pandemic. It should be noted that a significant increase is noted in comparison to Q1 & Q2 due to a change in system functionality as the hospital moved to a new IT system. Work is ongoing to reflect an accurate position in the Quality Performance Report.	>910 Chief Operating Officer - Acute Services
Rate of Emergency readmission within 30 days of a previous inpatient discharge		At present the re-admission review process has been suspended however due to the increase this is under review. Recent deep dive work has shown however we benchmark good against the UK.	>10% Chief Operating Officer - Acute Services

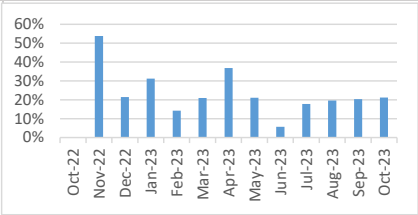
MENTAL HEALTH			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
% of clients who started treatment in period who waited over 18 weeks		The trend of an increase in the referrals to Jersey Talking therapies continues from July this year. In October the number of referrals to JTT was 125. We remain well within our KPI for waiting time for assessment, however we remain above our KPI for waiting times to start treatment. We have an increase in the number of people starting treatment from the previous month to 58 in October and an increase in contacts in October to 437 contacts. We have a new Senior Psychological therapist who has joined the team and we are in the process of recruiting additional step 2 practitioners, which will have a positive impact on waiting times for treatment. Treatment outcome measures have now returned to both being within the KPI range (for completed treatment and reliable improvement)	>5% Director Mental Health & Adult Social Care
Memory Service - Average Time to assessment (Days)		Waiting time for assessment / diagnosis remains a challenge - now at 190 days from referral. Work is ongong within the care group to identify additional medical / diagnostic capacity into the team.	>138 Director Mental Health & Adult Social Care
% of referrals to Mental Health Crisis Team assessed in period within 4 hours		The crisis team have completed a face to face assessment within 4 hours in 77% of cases this month, against a KPI target of 85%. This is comparatively low in terms of the performance of the team. As previously, this is reviewed in detail each month to understand all occurrences when this is not achieved. The reasons for this can include another assessment being underway already (out of hours); patient choice; or medical treatment needs prior to assessment being possible. The team continue to aim to achieve the 85% target.	<85% Director Mental Health & Adult Social Care

% of referrals to Mental Health Assessment Team assessed in period within 10 working days		The target of assessing all referrals to mental health services was achieved in 82% of the 251 referrals to the service this month (against a KPI target of 85%). As previously explained, the key factor in not completing the assessment within 10 days tends to be patient choice; this is reviewed in detail each month by the team leader.	<85% Director Mental Health & Adult Social Care
Older adult acute bed occupancy (including leave)		Bed occupancy in older adult mental health services remains above benchmarking due to the number of medically fit for discharge / delayed transfers of care into community placements (although this has reduced in month from 11 patients to 9).	>85% Director Mental Health & Adult Social Care

SOCIAL CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
Percentage of clients with a Physical Health check in the past year		Health assessments have increased slightly which is positive in terms of people receiving an annual health check. It has been noted that within reporting, this does not identify those service users who are offered but do not want to have a health assessment. The Learning Disability Services are therefore looking at revising the documentation on Care Partner to report these to ensure that these can be evidenced (especially when the service user or carer reports that the health check is being undertaken elsewhere).	>=80% Director Mental Health & Adult Social Care
Percentage of new Support Plans reviewed within 6 weeks (ASCT)		The % of reviews within 6 weeks KPI is recovering from the previously reported challenges in capacity to complete initial reviews in August/September. This function was brought back under the Adult Social Care team in late September. Plans to further bolster the Hospital Discharge Service and move hospital reviews to that team are underway (currently subject to staff consultation). The care group leadership team will continue to monitor to ensure further improvement.	>=80% Director Mental Health & Adult Social Care

WOMEN'S AND CHILDREN'S SERVICES			
Was Not Brought Rate		This is across the whole of HCS and is not reflective of just the women and children's care group. Appointment reminder text messages are not being sent to patients as it has become an opt-in function. The care group expect an improvement once the system has been upgraded. Actions currently in place are telephone calls by clinical teams at time of appointments if a DNA has occurred and a follow-up letter/appointment sent as required. Clinic outcomes are monitored weekly to cross-check any missed outcomes.	>9.8% Chief Operating Officer - Acute Services
Rate of Vaginal Birth After Caesarean (VBAC)		The rate is low for October. This is mother led and cannot be seen as a quality target. NICE recommend that women can chose their mode of delivery. Women are counselled and given information relating to vaginal birth after caesarean so that they are able to make an informed choice regarding the mode of delivery.	< 25% Chief Nurse
% 3rd & 4th degree tears – normal birth		Although the rate for October was higher than expected this is a recognised complication of childbirth. Reviewing the year to date it would appear the rate would be less than 2.5%. These tears are repaired by a senior obstetrician and women are reviewed postnatally.	>2.5% Chief Nurse
% of births less than 37 weeks		We are actively screening for maternal and fetal conditions that warrant early delivery.	>10% Chief Nurse
% births requiring Jersey Neonatal Unit admission		This would be reflective of babies less than 37 weeks who would require extra support and monitoring.	>5.05% Chief Nurse
% of babies that have APGAR score below 7 at 5 mins		The babies that had Apgar's below 7 made a good recovery and were discharged home. This was reflective of babies that were delivered less than 37 weeks gestation (as above).	>0.6% Chief Nurse

QUALITY AND SAFETY			
Pseudomonas Bacteraemia - Hosp		Unlikely if the 1 case of pseudomonas bacteraemia was a true infection however most likely a contaminated sample as source unknown	0 Chief Nurse
C-Diff Cases - Hosp		We had 2 cases of hospital onset C difficile infection in one ward in October, but these were different ribotype and therefore these cases were not linked	1 Chief Nurse
Number of medication errors across HCS resulting in harm per 1000 bed days		Reported medication errors have included miscounts of prescriptions, spillages of medication or wasted medication. There have been no reported errors in relation to opiate medication and no serious incidents in relation to medication errors.	> 0.40 Medical Director
% of adult inpatients who have had a VTE risk assessment within 24 hours of admission		Medical Director's Office has investigated this trend in discussion with the Care Groups. Data on VTE assessment is pulled from Maxims and this data with respect to the recording of assessment in Maxims is correct. However, all Care Groups having reviewed and discussed this trend with the Medical workforce believe the prescribing of prophylaxis to be far better than this trend would suggest. A focussed piece of work is being undertaken to mandate the prescribing of prophylaxis within EPMA. However, a further piece of work needs to occur to educate medical colleagues in evidencing that an assessment has occurred by recording it within Maxims.	>97% Medical Director

% of all complaints closed in the period which were responded to within the target		October has seen a very slight improvement over previous months, with an overall reduction of the number of open complaints that are overdue their agreed response date (down to 63.9% as of 14/11/23). Three new complaints were received during the month of September 2023, and 13 new complaints were received in the month of October 2023. At the time of reporting, 36.1% of open Stage 1 complaints are within the 5-day timescale, 44.4% are between 6-100 days overdue, and 19.4% are over 101 days from the response due date (in total there are 36 open Stage 1 complaints, 4 Stage 2, and 3 Stage 3 complaints), the complainants of those complaints which are overdue are being contacted to update and agree new timescales to bring this metric back on track). New processes are also now being implemented to address performance; focused on increasing contact with complainants to agree revised response timescales when we are aware of delays in the investigation process (this will reduce the number of overdue complaints in line with the Feedback Policy), revising the process for care group oversight and sign-off to ensure more timely response rates across staff groups, reinforcing the distinction between PALS and complaints, with clear guidelines for escalation and closure to address the length of time complaints remain open, and changes to the Datix system to improve reporting and more accurately record the learning and actions taken as a result of patient feedback. These measures are being implemented in conjunction with the development of HCS specific guidance in the form of a complaints/feedback manual, and specific training that will be included in all staff inductions to improve the culture of complaint management, prompt patient feedback, improved narrative of performance, themes, and learning.	<40% Chief Nurse

CHANGES AND TECHNICAL NOTES

As part of our commitment to enhancing the quality of our services, we have developed performance indicators to track our progress and provide greater transparency into our operations. These indicators enable us to better monitor our performance towards achieving our objectives and make informed decisions about the future of our services.
However, please note these indicators may be subject to change in future versions of this report as we strive to refine our approach and respond to the changing needs of the community. We remain dedicated to providing accurate and insightful performance data and therefore use the most accurate data available at the time of publication.

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

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

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

For indicators related to Medically Fit for Discharge and Delayed Transfers of Care, only snapshot data are currently available from new Patient Administration System. Informatics have been working with the supplier to identify a fix. In the meantime we have introduced a workaround method to store the snapshots to be able to calculate these indicators. As this was implemented in early August, the first full month that will be able to be calculated is September (month 9).

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

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

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

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

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

APPENDIX - DATA SOURCES

DEMAND

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

ACTIVITY

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

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

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

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

PLANNED (ELECTIVE) CARE						
	INDICATOR	SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Outpatients	New to follow-up ratio	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	Chief Operating Officer - Acute Services	2.0	Standard set locally	Rate of new (first) outpatient appointments to follow-up appointments. This being the number of follow-up appointments divided by the number of new appointments in the period. Excludes Private patients.
	Outpatient Did Not Attend (DNA) Rate	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	Chief Operating Officer - Acute Services	<8%	Standard set locally	Percentage of public General & Acute outpatient appointments where the patient did not attend and no notice was given. Numerator: Number of General & Acute public outpatient appointments where the patient did not attend. Denominator: the number of attended and unattended appointments
Elective Inpatients	Acute elective Length of Stay (LOS)	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM))	Chief Operating Officer - Acute Services	<3	Standard set locally	Average (mean) Length of Stay (LOS) in days of all elective inpatients discharged in the period from a Jersey General Hospital ward. All days of the stay are counted in the period of discharge. E.g. a patient with a 100 day LOS, discharged in January, will have all 100 days counted in January. This indicator excludes Samares Ward. During the period 2020 to 2022 Samares Ward was closed and long stay rehabiliation patients were treated on Plemont Ward and therefore the data is not comparable for this period.
	% of all elective admissions that were day cases	Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B) & Maxims Theatres Report (TH1DM))	Chief Operating Officer - Acute Services	>80%	Standard set locally	Percentage of elective admissions for surgery that are managed as day cases (with same day discharge). Numerator: Number of elective surgical day case admissions both public and private. Denominator: Total surgical elective admissions
	% of all elective admissions that were private	Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B) & Maxims Theatres Report (TH1DM))	Chief Operating Officer - Acute Services	>32% and <34%	Based on clinical job plans	Number of private elective admissions divided by the total number of elective admissions

Theatres	Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations)	Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B), TrakCare Theatres Report (OPT11A), Maxims Theatres Report (TH001DM) & Maxims Session Booking Report (TH002DM))	Chief Operating Officer - Acute Services	>85%	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.
	Turnaround time as % of total session time	Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B), TrakCare Theatres Report (OPT11A), Maxims Theatres Report (TH001DM) & Maxims Session Booking Report (TH002DM))	Chief Operating Officer - Acute Services	<15%	Standard set locally	Numerator: Sum of the time duration between successive patients within a single theatre session Denominator: Total theatre session duration. This is reported for all operation lists containing multiple operations (Public and Private) to take account of mixed lists.

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

Emergency Inpatients	Non-elective acute Length of Stay (LOS)	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM))	Chief Operating Officer - Acute Services	<10	Generated based on historic performance	Average (mean) Length of Stay (LOS) in days of all emergency inpatients discharged in the period from a General Hospital ward. All days of the stay are counted in the period of discharge. E.g. a Patient with a 100 day LOS, discharged in January, will have all 100 days counted in January. This indicator excludes Samares Ward. During the period 2020 to 2022 Samares Ward was closed and long stay rehabiliation patients were treated on Plemont Ward and therefore the data is not comparable for this period.
	% Emergency admissions with 0 Length of Stay (Same day discharge)	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions and Discharge Report (IP13DM))	Chief Operating Officer - Acute Services	<17%	Generated based on historic performance	Percentage of emergency (non-elective) inpatient admissions that were discharged the same day. Numerator: Total ED attendances that were discharged the same day. Denominator: Total ED attendances.
	Acute bed occupancy at midnight (Elective & Non-Elective)	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	Chief Operating Officer - Acute Services	<85%	Generated based on historic performance	Percentage of beds occupied at the midnight census, JGH and Overdale. Numerator: Number of beds occupied by a patient at midnight in the period. Denominator: Number of beds either occupied or marked as available for a patient at the midnight census
	% of Inpatients discharged between 8am and noon	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM))	Chief Operating Officer - Acute Services	>=15%	Generated based on historic performance	% of inpatients discharged from General & Acute wards between 8am and Noon. Excluding private patients, self discharges and deceased patients. Numerator: Patients discharged between 8am and 12 noon in period. Denominator: Total patients discharged in period
	Average daily number of patients Medically Fit For Discharge (MFFD)	Hospital Electronic Patient Record (TrakCare Current Inpatients Report (ATD49) & Maxims Current Inpatients Report (IP20DM))	Chief Operating Officer - Acute Services	<30	Generated based on historic performance	Average (mean) number of inpatients marked as Medically Fit each day at 8am, JGH/Overdale only
	Total Bed Days Medically Fit For Discharge	Hospital Electronic Patient Record (TrakCare Current Inpatients Report (ATD49) & Maxims Current Inpatients Report (IP20DM))	Chief Operating Officer - Acute Services	<910	Generated based on historic performance	Sum of bed days in period of patients marked as Medically Fit
	Total Bed Days Delayed Transfer Of Care (DTOC)	Hospital Electronic Patient Record (TrakCare Current Inpatients Report (ATD49) & Maxims Current Inpatients Report (IP20DM))	Chief Operating Officer - Acute Services	NA	Not Applicable	Sum of bed days in period of patients marked as Delayed Transfer Of Care (DTOC)
	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))	Chief Operating Officer - Acute Services	<10%	Generated based on historic performance	The rate of emergency readmission. This being the number of eligible emergency admissions to Jersey General Hospital occurring within 30 days (0-29 days inclusive) of the last, previous eligible discharge from hospital as a percentage of all eligible discharges from JGH and Overdale. Exclusions apply see detailed definition at: https://files.digital.nhs.uk/69/A27D29/Indicator%20Specification%20-%20Compendium%20Readmissions%20%28Main%29%20-%20I02040%20v3.3.pdf

MENTAL HEALTH						
	INDICATOR	SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Jersey Talking Therapies	% of clients waiting for assessment who have waited over 90 days	JTT & PATS electronic client record system	Director Mental Health & Adult Social Care	<5%	Improving Access to Psychological Therapies (IAPT) Standard	Number of JTT clients who have waited over 90 days for assessment, divided by the total number of JTT clients waiting for assessment
	% of clients who started treatment in period who waited over 18 weeks	JTT & PATS electronic client record system	Director Mental Health & Adult Social Care	<5%	Improving Access to Psychological Therapies (IAPT) Standard	Percentage of JTT clients waiting more than 18 weeks to commence treatment. Numerator: Number of JTT clients beginning treatment who waited longer than 18 weeks from referral date. Denominator: Total number of JTT clients beginning treatment in the period
	JTT Average waiting time to treatment (Days)	JTT & PATS electronic client record system	Director Mental Health & Adult Social Care	<=177	Generated based on historic percentiles	Average (mean) days waiting from JTT referral to the first attended treatment session
	% of eligible cases that have completed treatment and were moved to recovery	JTT & PATS electronic client record system	Director Mental Health & Adult Social Care	>50%	Improving Access to Psychological Therapies (IAPT) Standard	Number of JTT referrals which match the services eligibility criteria that completed treatment and were moved to recovery (defined as a clinical case at the start of their treatment and are no longer defined as a clinical case at the end of their treatment), divided by the total number of JTT referrals which match the services eligibility criteria
	% of eligible cases that have shown reliable improvement	JTT & PATS electronic client record system	Director Mental Health & Adult Social Care	>75%	Improving Access to Psychological Therapies (IAPT) Standard	Number of JTT referrals which match the services eligibility criteria that showed reliable improvement (there is a significant improvement in their condition following a course of treatment, measured by the difference between their first and last scores on questionnaires tailored to their specific condition), divided by the total number of JTT referrals which match the services eligibility criteria
Community Mental Health	Memory Service - Average Time to assessment (Days)	Community services electronic client record system	Director Mental Health & Adult Social Care	<138	Generated based on historic percentiles	Average (mean) days waiting from the date of referral to the assessment date for all those who have been referred and assessed under the Memory Assessment Service centre of care
	% of referrals to Mental Health Crisis Team assessed in period within 4 hours	Community services electronic client record system	Director Mental Health & Adult Social Care	>85%	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	Director Mental Health & Adult Social Care	>85%	Agreed locally by Care Group Senior Leadership Team	Percentage of referrals to Mental Health Assessment Team that were assessment within 10 working day target. Numerator: Number of Assessment Team referrals assessed within 10 working days of referral. Denominator: Total number of Mental Health Assessment Team referrals received
	% of Adult Acute discharges with a face to face contact from an appropriate Mental Health professional within 3 days	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Admissions Report (ATD5L), Maxims Discharges Report (IP013DM), Maxims Admissions Report (IP013DM) & Community services electronic client record) system	Director Mental Health & Adult Social Care	>80%	National standard evidenced from Royal College of Psychiatrists	Number of patients discharged from 'Orchard House' with a Face-to-Face contact from Community Mental Health Team (CMHT, including Adult & Older Adult services) or Home Treatment within 72 hours divided by the total number of discharges from 'Orchard House'
	% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Admissions Report (ATD5L), Maxims Discharges Report (IP013DM), Maxims Admissions Report (IP013DM) & Community services electronic client record) system	Director of Mental Health Services	>80%	National standard evidenced from Royal College of Psychiatrists	Number of patients discharged from an 'Older Adult' unit with a Face-to-Face contact from Older Adult Community Mental Health Team (OACMHT) or Home Treatment within 72 hours divided by the total number of discharges from 'Older Adult' units

	Community Mental Health Team did not attend (DNA) rate	Community services electronic client record system	Director Mental Health & Adult Social Care	<10%	Standard based on historic performance	Rate of Community Mental Health Team (CMHT) outpatient appointments not attended. Numerator: Number of Community Mental Health Team (CMHT, including Adult & Older Adult services) public outpatient appointments where the patient did not attend. Denominator: Total number of Community Mental Health Team (CMHT, including Adult & Older Adult services) appointments booked
Inpatient Mental Health	Adult Acute Admissions per 100,000 population - Rolling 12 month	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions Report (IP013DM))	Director Mental Health & Adult Social Care	<255	NHS Benchmarking Network 2021/22 upper quartile. For green (<240) this reflects an improvement on GOJ 2021 performance.	Number of admissions to 'Orchard House' in the past 12 months from the reporting month for every 100,000 population
	Adult acute admissions under the Mental Health Law as a % of all admissions	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), Maxims Admissions Report (IP013DM) & Mental Health Articles Report)	Director Mental Health & Adult Social Care	<37%	Jersey has a much lower rate than NHS Benchmarking Network. Standard is based on local historic benchmarking	Number of 'Orchard House' admissions under a formal Mental Health article, divided by total number of admissions to 'Orchard House'
	Adult acute bed occupancy at midnight (including leave)	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	Director Mental Health & Adult Social Care	<88%	Generated based on historic performance	Percentage of beds occupied at the midnight census, Orchard House. Numerator: Number of beds occupied by a patient at midnight in the period, including patients on leave. Denominator: Number of beds either occupied or marked as available for a patient at the midnight census
	Older Adult Admissions per 100,000 population - Rolling 12 month	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions Report (IP013DM))	Director Mental Health & Adult Social Care	<475	Jersey is an extreme outlier in the NHS Benchmarking Network. Standard set based on improving 2021 performance toward the NHS Benchmarking Network mean	Number of admissions to 'Older Adults' units, in the past 12 months from reporting month, for every 100,000 population
	Older adult acute bed occupancy (including leave)	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	Director Mental Health & Adult Social Care	<85%		Percentage of beds occupied at the midnight census, Beech and Cedar Wards. Numerator: Number of beds occupied by a patient at midnight in the period, including patients on leave. Denominator: Number of beds either occupied or marked as available for a patient at the midnight census
	Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health inpatient wards	Hospital Electronic Patient Record (TrakCare Current Inpatient Report (ATD49) & Maxims Current Inpatient Report (IP020DM))	Director Mental Health & Adult Social Care	<13	Generated based on historic percentiles	Average (mean) number of Mental Health inpatients marked as Medically Fit each day at 8am

SOCIAL CARE						
	INDICATOR	SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Learning Disability	Percentage of clients with a Physical Health check in the past year	Community services electronic client record system	Director Mental Health & Adult Social Care	>80%	Generated based on historic performance	Percentage of Learning Disability (LD) clients with an open involvement in the period who have had a physical wellbeing assessment within the past year. Numerator: Number of LD clients who have had a physical wellbeing assessment in the 12 months prior to period end. Denominator: Total number of clients with an open LD involvement within the period.
Adult Social Care Team (ASCT)	Percentage of Assessments completed and authorised within 3 weeks (ASCT)	Community services electronic client record system	Director Mental Health & Adult Social Care	>=80%	Generated based on historic performance	Number of FACE Support Plan and Budget Summary opened in the ASCT centre of care that are opened then closed within 3 weeks, divided by the total number of FACE Support Plan and Budget Summary opened in the ASCT centre of care more than 3 weeks ago
	Percentage of new Support Plans reviewed within 6 weeks (ASCT)	Community services electronic client record system	Director Mental Health & Adult Social Care	>=80%	Generated based on historic performance	Percentage of Support Plan Reviews in the ASCT Centre of Care (only counting those that follow a FACE Support Plan) that were opened within 6 weeks of closing a FACE Support Plan in the ASCT Centre of Care

WOMENS AND CHILDRENS SERVICES						
INDICATOR		SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Children	Was Not Brought Rate	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	Chief Operating Officer - Acute Services	<=10%	Standard set locally based on average (mean) of previous two years' data	Percentage of JGH/Overdale public outpatient appointments where the patient did not attend (was not brought). Numerator: Number of JGH/Overdale public outpatient appointments where the patient did not attend. Denominator: Number of all attended and unattended appointments. Under 18 year old patients only. All specialties included.
	Average length of stay on Robin Ward	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Discharges Report (IP013DM))	Chief Operating Officer - Acute Services	<=1.65	Standard set locally based on average (mean) of previous two years' data	Average (mean) length of stay in days of all patients discharged in the period from Robin Ward, including leave days
Maternity	% deliveries home birth (Planned & Unscheduled)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	NA	Not Applicable	Percentage of deliveries home births (Planned & Unscheduled) out of the total number of deliveries in the period. Numerator: Number of deliveries recorded as being at "Home" (regardless of whether they were 'planned' or 'unplanned') in the period. Denominator: number of deliveries in the period.
	% Spontaneous vaginal births (including home births and breech vaginal deliveries)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	NA	Not Applicable	Number of spontaneous vaginal births including home births and breech vaginal deliveries dividved by total number of deliveries
	% Instrumental deliveries	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	NA	Not Applicable	Number of Instrumental deliveries divided by total number of deliveries
	% Emergency caesarean section births	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	NA	Not Applicable	Number of Emergency Caesarean sections, divided by total number of deliveries
	% Elective caesarean section births	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	NA	Not Applicable	Number of Elective Caesarean sections, divided by total number of deliveries
	% of women that have an induced labour	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	<=27.57%	Standard set locally based on average (mean) of previous two years' data	Percentage of women that have an induced labour in the period. Numerator: Number of women that had an induced labour. Denominator: number of deliveries.
	Number of stillbirths	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	0	Stanadard set locally based on historic performance	Number of stillbirths (A death occurring before or during birth once a pregnancy has reached 24 weeks gestation)
	Rate of Vaginal Birth After Caesarean (VBAC)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	>15%	As the Jersey numbers that drive this indicator are so low and have such a skewed distribution across the last two years, standard set to match the NHS National value of 15%.	Number of Vaginal Births after Caesarean (VBAC) divided by the total number of Births after Caesarean
	% primary postpartum haemorrhage >= 1500ml	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	<=6.75%	NHS National Value is 3%. However, as the Jersey numbers that drive this indicator are so low, the standard has been set locally based on average (mean) of previous two years' data	Percentage of deliveries that resulted in a blood loss of over 1500ml out of the total number of deliveries in the period. Numerator: Number of deliveries that resulted in a blood loss of over 1500ml. Denominator: number of deliveries
	% 3rd & 4th degree tears – normal birth	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	<2.5%	As the Jersey numbers that drive this indicator are so low and have such a skewed distribution across the last two years, we have set the standard to match the NHS National value of 2.5%.	Number of women who had a vaginal birth (not instrumental) and sustained a 3rd or 4th degree perineal tear as percentage of all normal births
	% of births less than 37 weeks	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	<=6.85%	NHS National Value is 6.3%. However, as the Jersey numbers that drive this indicator are so low, the standard has been set locally based on average (mean) of previous two years' data	Number of live babies who were born before 37 weeks (less than or equal to 36 weeks + 6 days gestation) divided by total number of live births

	% births requiring Jersey Neonatal Unit admission		Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Movements Report (ATD5PA), TrakCare Deliveries Report (MAT23A), Maxims Discharges Report (IP013DM), Maxims Movements Report (IP001DM) & Maxims Deliveries Report (MT005))	Chief Nurse	<=5.05%	Standard set locally based on average (mean) of previous two years' data	Number of births requiring admission to the Jersey Neonatal Unit, divided by total number of births
	% of babies that have APGAR score below 7 at 5 mins		Hospital Electronic Patient Record (TrakCare Maternity Reports (MAT23A & MAT1A) & Maxims Maternity Reports (MT005 & MT001))	Chief Nurse	<=1.3%	NHS National Value is 1.2%. However, as the Jersey numbers that drive this indicator are so low, the standard has been set locally based on average (mean) of previous two years' data	Percentage of deliveries that have APGAR score (a measure of the physical condition of a newborn baby) below 7 at 5 minutes after birth
	Average length of stay on maternity ward		Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Discharges Report (IP013DM))	Chief Nurse	<=2.28	Standard set locally based on average (mean) of previous two years' data	Average (mean) length of stay for all patients discharged in the period from the Maternity Ward

QUALITY AND SAFETY							
INDICATOR			SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Infection Control	MRSA Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Chief Nurse	0	Standard based on historic performance	Number of Methicillin Resistant Staphylococcus Aureus (MRSA) cases in hospital in the period, reported by the IPAC team
	MSSA Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Chief Nurse	0	Standard based on historic performance	Number of Methicillin-Susceptible Staphylococcus Aureus (MSSA) cases in the hospital in the period, reported by the IPAC team
	E-Coli Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Chief Nurse	0	Standard based on historic performance	Number of E. Coli bacteraemia cases in the hospital in the period, reported by the IPAC team
	Klebsiella Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Chief Nurse	0	Standard based on historic performance	Number of Klebsiella bacteraemia cases in the hospital in the period, reported by the IPAC team
	Pseudomonas Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Chief Nurse	0	Standard based on historic performance	Number of Pseudomonas bacteraemia cases in the hospital in the period, reported by the IPAC team
	C-Diff Cases - Hosp	Hosp	Infection Prevention and Control Team Submission	Chief Nurse	1	Standard based on historic performance (2020)	Number of Clostridium Difficile (C-Diff) cases in hospital in the period, reported by the IPAC team
Safety Events	Number of falls resulting in harm (low/moderate/severe) per 1,000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Chief Nurse	NA	No Standard Set	Number of inpatient falls with harm recorded where approval status is not "Rejected" per 1000 occupied bed days
	Number of falls per 1,000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Chief Nurse	<6	Standard based on historic performance	Rate of recorded inpatient falls per 1000 bed days. Numerator: Number of inpatient falls recorded in the period where the approval status is not "Rejected". Denominator: Number of occupied bed days in the period in General Hospital, Overdale and Acute Mental Health wards
	Number of medication errors across HCS resulting in harm per 1000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Medical Director	<0.40	Standard set locally based on improvement compared to historic performance	Number of medication errors across HCS (including Mental Health) resulting in harm where approval status is not "Rejected" per 1000 occupied bed days. Note that this indicator will count both inpatient and community medication errors due to recording system limitations. As reporting of community errors is infrequent and this indicator is considered valuable, this limitation is accepted.
	Number of serious incidents		HCS Incident Reporting System (Datix)	Chief Nurse	NA	Standard removed 2022-09-28 per Q&R Committee instruction	Number of safety events recorded in Datix in the period where the event is marked as a 'Serious Incident'

VTE	% of adult inpatients who have had a VTE risk assessment within 24 hours of admission		Hospital Electronic Patient Record (Maxims Report IP026DM)	Medical Director	>95%	NHS Operational Standard	Percentage of all inpatients (17 and over), (excluding paediatrics, maternity, mental health, and ICU) that have a VTE assessment recorded through IMS Maxims within 24 hours of admission or before as part of pre-admission. Numerator: Number of eligible inpatients that have a VTE assessment recorded through IMS Maxims within 24 hours of admission or before as part of pre-admission. Denominators: Number of all inpatients that are eligible for a VTE assessment.
Pressure Ulcers	Number of pressure ulcers acquired as an inpatient per 1,000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Chief Nurse	<2.87	Standard set locally based on improvement compared to historic performance	Number of inpatient pressure ulcers where approval status is not "Rejected" per 1000 occupied bed days
	Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days	Hosp	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Chief Nurse	<1.96	Standard set locally based on improvement compared to historic performance	Number of inpatient Cat 2 pressure ulcers where approval status is not "Rejected" per 1000 occupied bed days
	Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Chief Nurse	<0.60	Standard set locally based on improvement compared to historic performance	Number of inpatient Cat 3 & 4 pressure ulcers where approval status is not "Rejected" per 1000 occupied bed days
Feedback	Number of complaints received		HCS Feedback Management System (Datix)	Chief Nurse	NA	Not Applicable	Number of formal complaints received in the period where the approval status is not "Rejected"
	Number of compliments received		HCS Feedback Management System (Datix)	Chief Nurse	NA	Not Applicable	Number of compliments received in the period where the approval status is not "rejected"
	Number of comments received		HCS Feedback Management System (Datix)	Chief Nurse	NA	Not Applicable	Number of comments received in the period where approval status is not "Rejected"
	% of all complaints closed in the period which were responded to within the target		HCS Feedback Management System (Datix)	Chief Nurse	>40%	Response time standards are those in GoJ Feedback Policy which does not set achievement targets, so target set locally	Percentage of all complaints closed in the period responded to within the target time as set by GoJ Feedback Policy. Numerator: Number of all closed complaints in the period, responded to within the target. Denominator: Number of complaints closed in the period.

Health and Community Services

Health and Community Services Advisory Board Report

Report to:	Health and Community Services Advisory Board		
Date of meeting:	06th December 2023		
Title of paper:	Waiting List Report		
Report author (& title):	Andrew Carter, Head of Access	**Accountable Executive:**	Claire Thompson, Chief Operating Officer, Acute Services

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board?	To advise and inform the Health and Community Services (HCS) Advisory Board of the current waiting list position of six key areas including information of the current restraints and issues, management actions and timelines for recovery. The six key areas are, • Ophthalmology, • Endoscopy, • Trauma and Orthopaedics (T&O), • Magnetic Resonance Imaging (MRI), • Dermatology, • Patients waiting > 90 days on community Patient Tracking List	Information	x
		Decision	
		Assurance	x
		Update	x

2. Executive Summary

The paper describes five speciality pathways of challenged waiting lists with context and background of the issues and management actions being taken to address and timeline for impact for improved access to treatment. In connection with this, HCS harm review policy is under development to provide increased assurance regarding any impact to patients. It is planned to be approved and implemented by January 2024. This has been considered as part of the review of quality performance metrics as historic Quality and Performance Report (QPR) has focused on waits over 90 days and harm review policy elsewhere has focused on waits over 52 weeks.

The board asked for specific updates for this month's reports for the following key areas:

- Endoscopy
- Ophthalmology
- Trauma and Orthopaedics
- MRI
- Dermatology
- Patients waiting > 90 days on the community PTL

3. Finance / workforce implications

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

4. Risk and issues

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

5. Applicability to ministerial plan

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

6. Main Report

Endoscopy:

In August 2023 Health and Community Services appointed Xyla Elective Care Limited to fulfil an endoscopy insourcing requirement at weekends in Jersey General Hospital. The service completed the first eight-week period of endoscopy on the week ending the 26th November 2023. In this period, 388 patients had their diagnostic procedures equating to 667 Joint Advisory Group (JAG) points.

In relation to the waiting list, the project commenced on the 7th October with a total waiting list volume of 1170 patients. This has been reduced to 815 patients during the eight-week period, a reduction of 355 (-30.3%). Please see Appendix One for the project's performance against trajectory. The second eight-week phase of endoscopy is in planning with an intended start date of 03rd February 2024 until the 31st March 2024 where the project remains on track to reduce the total waiting list volume to 684. A medium-term view of the service will be developed early 2024 to ensure sustainability of performance.

The department risk stratifies its referrals due to the implementation of the Faecal Immunochemical Test (FIT) testing programme last year and at triage and as a result prioritises Urgent and Soon patients. The insourcing project, therefore, focused on the backlog of routine patients, built up from demand exceeding capacity. At the time of writing this report, there is outstanding histology to be reported on and reviewed from the final weekends of the project. However, at this point no new cancer cases have been diagnosed, nine patients have been diagnosed with new chronic conditions and 51 patients require repeat procedures in line with surveillance guidelines. 15 patients booked into the weekend service did not complete the procedure on the day due to bowel prep or being unable to tolerate the procedure resulting in a 97% completion rate.

Furthermore, in relation to patient experience, Appendix Two demonstrates the results of the patient experience survey from 33 respondents surveyed in October 2023. (November analysis is still being collated).

Ophthalmology:

Clinical Outsourcing Project

Health and Community Services have been engaging with external quality assured providers to assist in supporting the identification of a suitable outsourced delivery model. The intended model will deliver an off

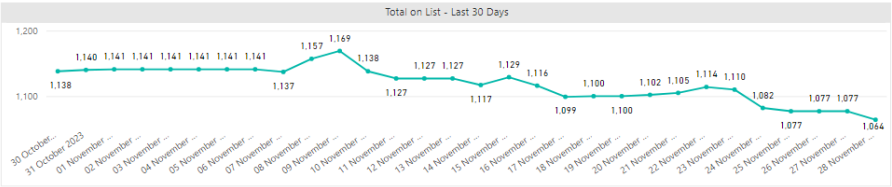
island surgical assessment and day case surgery solution for 500 cataract patients.

Following extensive market analysis HCS has been working with commercial services on the formation of the procurement strategy which was approved by the panel on the 14th of November. In line with the NHS Shared Business Services (NHSSB) Outsourced Clinical Services Framework, HCS intends to direct award to a single supplier and is working to formalise an award and mutually develop and agree the necessary service level agreement. The project remains on track to commence clinical activity as predicted in Quarter 1 2024.

Business As Usual Activity

HCS previously reported the successful recruitment to its last remaining medical vacancy, which for the purposes of Novembers report has now commenced in post. Furthermore, the locum covering the vacancy has been extended until the end of the year. This has resulted in capacity to focus on the backlog of routine patients awaiting their first outpatient consultation. The waiting list volume has reduced from 1169 patients to 1064 patient during this period. Furthermore, 188 of the longest waiting routine patients have been given appointments in the next 2-month period; this capacity will treat patients in chronological order who have waited from 21 months down to 12 months on the Patient Tracking List (PTL).

Figure 1: Ophthalmology Routine Waiting List Volume (First Outpatient Appointment) Trend



Trauma and Orthopaedics:

Trauma and orthopaedics have made a small improvement since Octobers report in relation to waiting list volume. The outpatient waiting list volume has decreased from 1275 patients to 1088 since the start of October (-187). This is primarily being driven by additional middle grade clinics on Friday afternoons as part of the waiting list recovery project. Additional clinics commenced on the 06/10/2023 with seven of the eight planned sessions going ahead (03/11/2023 cancelled due to storm Ciaran). The clinics have seen an additional 106 patients in the seven-week period.

Table 1: Additional T&O Clinics Activity

Date of Clinic	06/10/2023	13/10/2023	20/10/2023	27/10/2023	03/11/2023	10/11/2023	17/11/2023	24/11/2023	01/12/2023	08/12/2023	15/12/2023	22/12/2023	TOTAL
Booked	18	17	18	17	Cancelled	19	17	19	0	0	0	0	125
Seen	17	11	13	15	Cancelled	18	14	18	0	0	0	0	106
DNA	1	6	5	2	Cancelled	1	3	1	0	0	0	0	19
DNA Rate (%)	5.56%	35.29%	27.78%	11.76%	N/A	5.26%	17.65%						15.20%

In relation to the elective waiting list volume, November has delivered a small reduction compared to last month's report, reducing by 24 patients from 754 patients to 730 patients. HCS is funded to deliver an outsourced or insourced solution to assist with the back log of patients waiting for lower limb surgery, but this project remains in the early planning stages.

Magnetic Resonance Imaging (MRI)

The MRI recovery plan was instigated to tackle the increasing waiting list and waiting times for both public and private patients and is funded from the waiting list recovery programme. The recovery plan staffs the second MRI scanner for a time limited period via overtime but predominantly locum radiographers.

At the start of the programme the waiting list had peaked at 1,111 patients on the 06/09/2023. This has reduced to 344 patients as at the 22/11/2023, a reduction of 767 patients / 69%. In relation to waiting time this had reduced from 53 weeks down to 11 weeks for a routine appointment. The recovery plan remains on trajectory to reduce the routine wait to 6 weeks by the end of the project (22/12/2023).

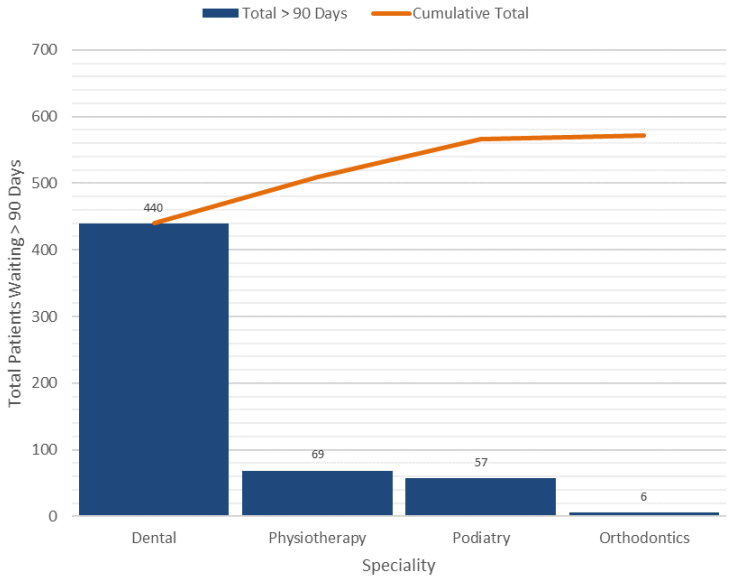
Table 2: MRI Total Patients on List

	06/09/2023	13/09/2023	20/09/2023	11/10/2023	25/10/2023	03/11/2023	07/11/2023	15/11/2023	22/11/2023
Patients on List	1111.00	1088.00	1071.00	744.00	577.00	637.00	598.00	480.00	344.00

% Of Patients Waiting > 90 Days (Community):

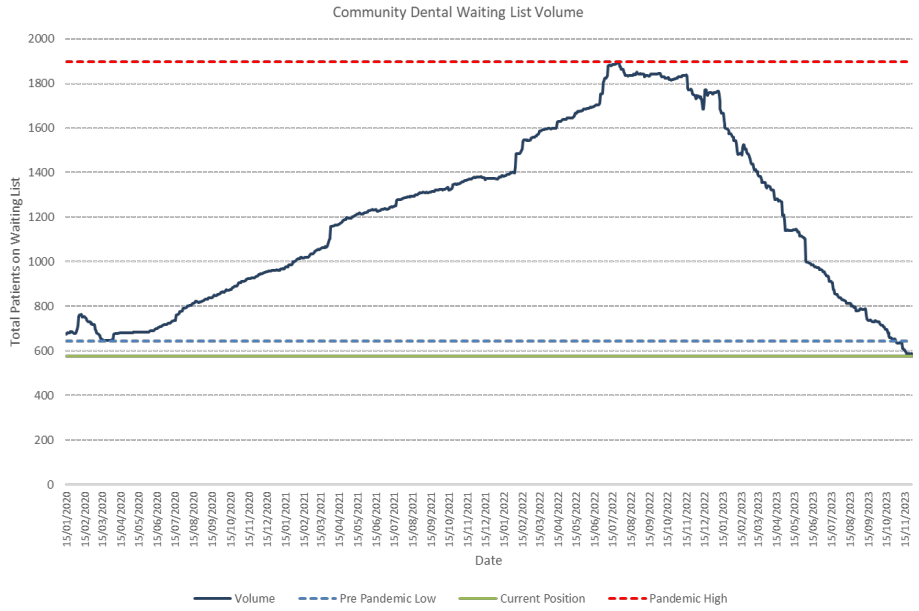
There are 572 patients waiting > 90 days across all community services, the pareto graph below demonstrates that this is primarily driven by Community Health Services Dental (77%).

Figure 2: Pareto Graph – Total patients waiting > 90 days on community waiting list by specialty.



The wait in Community Health Services Dental peaked at > 3 years and 1897 patients in July 2022 because of the pandemic. This is being addressed by the community dental commissioning project which has been live since October 2022 where HCS patients are seen and treated until dentally fit by dentists in the private sector. To-date the scheme has decreased the patient volume from 1897 patients to 577 patients (-1249); a reduction of 68.4%. Before the pandemic in January 2020 the total waiting list volume totalled 643 patients, 66 patients higher than November's figure as demonstrated below. The scheme is due to come to an end at the end of 2023. Opportunities to identify funding are being considered by the HCS Senior Leadership Team (SLT) as part of budget setting 2024 in order to continue with the scheme in 2024.

Figure 3: Community Dental Outpatient Waiting List Volume Since January 2020



Dermatology

Dermatology has been difficult to recruit to specialty nationally, with an advert out for a dermatology consultant position for two years, but JGH has been unsuccessful in recruitment during this time. In June 2023 a long-term locum left, and we have been unsuccessful in recruiting any suitable candidates with the skills to support the service following this. We have also had challenges with overseas applications for a middle grade post, resulting in a ten month and counting wait for a start date due to Visa and other on boarding requirements. The locum search has also been affected by the implementation of the tax changes in the UK. This reduced the number of patients being seen as we entered Q2 2023, as there was only one consultant in post with a reduction in service further exacerbated by sickness and pre-booked annual leave.

In November the surgical care group utilised capacity from General Surgery and re-organised the consultant dermatologist's outpatient clinics to create capacity to see urgent cases. This reduced the total Urgent volume from 203 patients to 168 patients in November. However, the total waiting list volume continued to increase (from 1326 to 1394). Staffing remains the primary constraint. Additional temporary workforce has been secured which will further impact in December 2023 and January 2024 and a medical photography option is being scoped to further aid recovery. This capacity will be defined further over the next month to inform waiting list reduction trajectory.

7. Recommendation

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

8. Appendices

Appendix 1 – Endoscopy Performance against Improvement Trajectory

Endoscopy

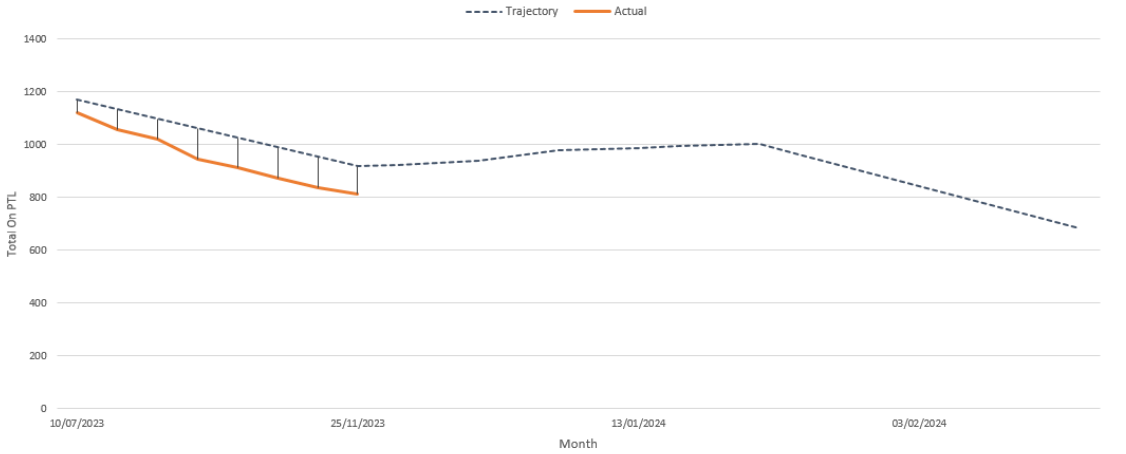
Diangostic Improvement Trajectory

Data Source: Endoscopy Diagnostic IMAS Model October 2023

Cumulative Change to Date: -355

Health and Community Services

	Wk 0	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10	Wk 11	Wk 12	Wk 13	Wk 14	Wk 15	Wk 16	Wk 17	Wk 18	Wk 19	Wk 20	Wk 21	Wk 22	Wk 23	Wk 24	Wk 25
Date	10/07/2023	14/10/2023	21/10/2023	28/10/2023	11/04/2023	11/11/2023	18/11/2023	25/11/2023	12/02/2023	12/09/2023	16/12/2023	23/12/2023	30/12/2023	01/06/2024	13/01/2024	20/01/2024	27/01/2023	02/03/2024	02/10/2024	17/02/2024	24/02/2024	03/02/2024	03/09/2024	16/03/2024	23/03/2024	30/03/2024
Trajectory	1170	1134	1098	1062	1026	990	954	918	925	932	939	959	979	984	989	994	999	1004	964	924	884	844	804	764	724	684
Actual	1120	1057	1022	945	913	874	838	815																		
Variance	-50	-77	-76	-117	-113	-116	-116	-103																		



Appendix 2 – Endoscopy Insourcing Feedback

END OF REPORT

Health and Community Services

Health and Community Services Advisory Board Report

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	6 December 2023		
Title of paper:	Finance Report		
Report author (and title):	Obi Hasan, Finance Lead Change Team, Interim Lead of Finance Business Partnering HCS	**Accountable Executive:**	Chris Bown, Chief Officer HCS

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board?	To provide an update on the Month 10 (M10) Financial position and year-end forecast To discuss current financial position and year-end forecast noting the risks and mitigations.	Information	x
		Decision	
		Assurance	x
		Update	x

2. Executive Summary

The Year-to-date (YTD) actual vs budget overspend has increased by £2.5m in M10 to £25.6m, showing a slowing down of £0.2m in the underlying monthly run-rate.

The FY23 year-end forecast has reduced to a deficit of £27.2m, with the forecast run rate reducing by £0.7m to an exit run-rate by year end of £1.7m overspend.

Year-to-date average run rate has remained at £2.6m overspend per month but the underlying monthly run-rate shows a reduction to £2.4m. The projected monthly overspend for the last 2 months of the year is forecast to reduce to just under £0.8m. This includes the expected receipts of two additional pay related funding items of £2.2m accounting for a monthly run-rate impact of £1.1m.

Key drivers of the overspend are:

- **Staff Costs** – YTD £9.8m overspend which includes £3.9m of opening budget pressure re agency/locum costs, a further £23.0m agency/locum overspend (191 FTE – 142 covering vacancies, 49 other), and £3.2m of overtime costs, which are substantially mitigated by underspends of £20.3m in substantive staffing due to vacant posts (473 FTE) across other Care Groups/Directorates.

  The FY23 year-end forecast is an overspend of £10.0m which includes an element of the opening pressure of £4.7m, £24.0m overspend on agency locums, partially mitigated by an £18.7m underspend on substantive staffing due to vacancies.

  The underlying factors driving these cost pressures are recruitment issues, dependency on temporary staffing, expansion/escalation beds, and loss in productivity since 2019. The main Care

Groups/Directorates accounting for this overspend are Medical Services, Surgical Services, and Women and Children.

The month-on-month movement is a forecast decrease of £1.2m, driven by an agency expenditure forecast decrease of £0.4m, and a £0.8m reduction in substantive staffing spend.

The forecast includes expected receipts of two additional pay related funding items of £2.2m from Treasury.

- **Non-Pay** – YTD £16.0m overspend which includes £6.7m part-year effect of the opening pressure with the remaining £9.3m overspend driven by capacity and activity pressures in Mental Health on off-Island placements and drugs £2.8m, Chief Nurse re Accommodation Service £1.2m (due to due accommodation costs exceeding rental income), Surgical Services £1.2m in relation to medical supplies and consumables in Theatres, Day Surgery Unit and Radiology, and Social Care on domiciliary care packages £1.0m. Other cost pressures are in Medical Director £0.9m, Medical Services £0.7m, Non-Clinical Support Services £0.6m, of which the majority relates to increased patient travel costs and Estates compliance works, and Estates & Hard FM maintenance works £0.6m.

  The FY23 year-end forecast is an overspend of £17.6m of which £9.2m relates to the opening budget pressure, with the remaining £8.4m spread across Care Groups.

  Income shows an over-achievement £0.2m due to Surgical Services private patient income underperformance due to a lack of surgical beds capacity from medical outliers and escalation beds, offset by overachievements in Chief Nurse from additional staff accommodation, and Mental Health and Intermediate Care in relation to Long Term Care Benefit. The FY23 year-end forecast is an over-achievement of £0.5m due to over-performance.

Reserves Position

HCS is allocated additional funds each year based on business cases approved by GoJ/COM (Council of Ministers) that are targeted towards specific projects and initiatives for improving the quality of care delivered. These reserves are Growth, Covid and Capital. The funding is non-recurrent and is provided on a case-by-case basis each year.

It should be noted that unlike traditional budget funding models where contingency budgets are often held by individual organisations or departments, GoJ policy is to hold any reserves centrally in Treasury with individual organisations/departments applying for funding based on need. Therefore, contingency reserves are held centrally and not accumulated at organisation/department level.

The year-end forecast reserves after accounting for further forecast expenditure of £5.9m to year-end is £1.67m made-up of growth, Covid and capital reserves.

The unspent reserves have been frozen to ring-fence in partial mitigation against the in-year deficit position. To-date £3.1m of reserves have been used to offset additional cost pressures.

Risk and issues

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

- Delays in recruitment to substantive posts to replace agency staff.
- Further substantive recruitment fill without replacing agency.
- Agency/Locums rates pressures due to stricter application of Jersey tax rules.
- Tertiary Care contracts relating to activity volumes.
- Mental Health placements and Social Care packages due to significant price variations
- Insufficient headroom to mitigate further cost pressures.

Financial Recovery Plan (FRP) - M10 Progress Update

- The FRP schemes identified as at M10 are £28m with a risk-adjusted value of £20m which are phased to be delivered over FY23 £3m, FY24 £12m and FY25 £10m.
- The immediate priority is to deliver the in-year savings target of £3m by the year end requiring a challenging run-rate reduction of £1m per month over 3m Oct-Dec-23. £3.3m savings have been identified vs the £3m target by the Care Groups supported by the newly established Programme Management and Delivery Team (PMDT).
- £0.6m has been delivered in M10 with the remaining £2.6m savings forecast over Nov-Dec-23 to year end.

Budget Planning FY24

The budget planning is process which started in October has been progressing at pace. There are significant challenges in completing budgets to meet the year-end deadline due to the complexity of the challenges to fit the funding within the budget available starting from the deficit position driven by identified cost pressures and overspends which historically has resulted in a sub-optimal allocation of resources and funding. Re-balancing to correct this requires making decisions on the optimal allocation and re-allocation of funding based on priority of service needs which will take a number of budget iterations to resolve.

Conclusion

The Board is asked to note the improvement in the FY23 forecast deficit to £27.2m and progress of the FRP savings delivery of £3m to achieve a £26m deficit position in line with the FRP Plan as agreed with Treasury. The key cost reduction and income improvement schemes the FRP targets include:

- Reduction in agency spend by recruiting substantive staff.
- Increasing income from surgical private patients and laundry income.
- Removing delays in recruitment to substantive posts to replace agency staff, reducing agency / locum rate pressures, tertiary care contracts commissioning relating to activity volumes, and reducing the significant price and activity variations in mental health and social care packages.

The budget planning is process is progressing at pace whilst tackling the significant challenges in completing budgets to meet the year-end deadline due to the complexity of prioritising the optimal allocation of funding within the available budget.

3. Main Report

The Year-to-date actual vs budget overspend has increased by £2.5m in M10 to £25.6m, showing a slowing down of £0.2m in the underlying monthly run-rate. The FY23 year-end forecast has reduced to a deficit of £27.2m, with the forecast run rate reducing by £0.7m to an exit run-rate by year end of £1.7m overspend.

Year-to-date average run rate has remained at £2.6m overspend per month but the underlying monthly run-rate shows a reduction to £2.4m. The projected monthly overspend for the last 2 months of the year is forecast to reduce to just under £0.8m. This includes the expected receipts of two additional pay related funding items of £2.2m accounting for a monthly run-rate impact of £1.1m.

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
HCS Categorisation	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Staff Costs	19,947	20,993	161,829	171,583	(9,754)	197,014	207,021	(10,007)	(6.0%)	(5.1%)
Non Pay	8,012	10,112	82,977	98,949	(15,972)	97,195	114,819	(17,624)	(19.2%)	(18.1%)
Income	(2,146)	(2,857)	(21,043)	(21,205)	162	(26,207)	(26,686)	479	0.8%	1.8%
Grand Total	25,813	28,248	223,763	249,328	(25,564)	268,002	295,154	(27,152)	(11.4%)	(10.1%)

The key drivers are:

Year-to-date (YTD) position £25.6 m deficit:

- **Staff Costs £9.8m overspend** which includes £3.9m of opening budget pressure re agency/locum costs, a further £23.0m agency/locum overspend (191 FTE – 142 covering vacancies, 49 other), and £3.2m of overtime costs, which are substantially mitigated by underspends of £20.3m in substantive staffing due to vacant posts (473 FTE) across other Care Groups/Directorates. The underlying factors driving these cost pressures are recruitment issues, dependency on temporary staffing, expansion/escalation beds, and loss in productivity since 2019. The main Care Groups/Directorates accounting for this overspend are Medical Services £8.6m, Surgical Services £2.9m, and Women and Children £1.4m.
- **Non-Pay £16.0m overspend** which includes £6.7m part-year effect of the opening pressure with the remaining £9.3m overspend driven by capacity and activity pressures in Mental Health on off-Island placements and drugs £2.8m, Chief Nurse re Accommodation Service £1.2m (due to due accommodation costs exceeding rental income), Surgical Services £1.2m in relation to medical supplies and consumables in Theatres, Day Surgery Unit and Radiology, and Social Care on domiciliary care packages £1.0m. Other cost pressures are in Medical Director £0.9m, Medical Services £0.7m, Non-Clinical Support Services £0.6m, of which the majority relates to increased patient travel costs and Estates compliance works, and Estates & Hard FM maintenance works £0.6m.
- **Income over-achievement £0.2m** due to Surgical Services private patient income underperformance of £1.9m offset by overachievements in Chief Nurse £0.8m from additional staff accommodation, and Mental Health £0.4m and Intermediate Care £0.3m in relation to Long Term Care Benefit.

FY23 year-end forecast £27.2m deficit:

- **Staff Costs are forecast to overspend by £10.0m** which includes an element of the opening pressure of £4.7m, £24.0m overspend on agency locums (191 FTE), partially mitigated by an £18.7m underspend on substantive staffing due to vacancies (473 FTE).
- The net impact above is made-up of agency/locums cost overspends in Medical Services £7.0m, Surgical Services £6.3m, Mental Health £4.4m, Women and Children Services £3.4m, Primary Care £1.2m, Medical Director £0.6m, Chief Nurse £0.3m, Intermediate Care £0.3m, and Jersey Care Model £0.2m, which are mitigated by substantive pay underspends of £18.7m due to vacancies in Mental Health £5.7m, Surgical Services £3.8m, Women & Children & Family Care £2.1m, Primary Care & Prevention £2.1m, Medical Director £1.6m, Chief Nurse £1.3m, Non-Clinical Support Services £0.8m, Estates & Hard FM £0.5m, Jersey Care Model £0.5m, Social Care £0.2m, and Improvement & Innovation £0.2m. The exception is Medical Services with a substantive pay forecast overspend of £2.6m.
- The month-on-month movement is a forecast decrease of £1.2m, driven by an agency expenditure forecast decrease of £0.4m, and a £0.8m reduction in substantive staffing spend.
- The forecast includes expected receipts of two additional pay related funding items of £2.2m from Treasury.
- **Non-Pay overspend £17.6m** of which £9.2m relates to the opening budget pressure, with the remaining £8.4m spread across Care Groups, with Mental Health £3.2m, Surgical Services £1.6m, Chief Nurse £1.6m, Social Care £1.5m, Tertiary Care £1.3m, Non-Clinical Support Services £1.0m, Estates £0.6m, Jersey Care Model £0.4m, and Medical Director £0.2m.
- **Income over-achievement £0.5m** is due to the under-performance in Surgery private patient income of £2.7m due to a lack of surgical beds capacity which is offset by over-performance in Chief Nurse £1.2m, Mental Health £0.7m, Intermediate Care £0.5m, Social Care £0.4m, Women and Children and Non-Clinical Support Services both £0.2m.

Financial Position By Care Group/Directorate:

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Care Groups & Directorates	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	936	612	5,890	5,387	504	6,604	6,094	510	8.6%	7.7%
Director General's Offic	(24)	582	(377)	7,029	(7,406)	1,149	9,001	(7,852)	(1,962.0%)	683.6%
Estates & Hard Facilitie	747	997	9,174	9,315	(141)	10,669	10,783	(114)	(1.5%)	(1.1%)
Improvement & Innovation	1,627	2,278	15,436	15,245	191	18,183	18,055	128	1.2%	0.7%
Intermediate Care	250	247	1,804	1,634	171	2,058	1,999	58	9.5%	2.8%
Jersey Care Model	433	365	4,328	4,705	(377)	5,193	5,392	(198)	(8.7%)	(3.8%)
Medical Director	785	1,093	7,632	7,119	514	9,168	8,220	948	6.7%	10.3%
Medical Services	5,442	7,163	46,156	55,646	(9,490)	55,186	65,282	(10,096)	(20.6%)	(18.3%)
Mental Health	3,345	3,475	27,356	29,053	(1,697)	32,840	33,967	(1,127)	(6.2%)	(3.4%)
Non-Clinical Support Ser	1,884	1,487	18,845	18,562	283	22,614	22,584	30	1.5%	0.1%
Primary Care & Preventio	905	804	8,694	8,140	554	9,982	9,124	858	6.4%	8.6%
Social Care	2,059	1,980	17,849	18,963	(1,113)	21,061	22,124	(1,063)	(6.2%)	(5.0%)
Surgical Services	4,377	4,633	34,762	40,799	(6,037)	41,789	48,618	(6,829)	(17.4%)	(16.3%)
Tertiary Care	1,067	630	10,666	11,072	(406)	12,799	14,072	(1,273)	(3.8%)	(9.9%)
Women Children & Family	1,979	1,903	15,546	16,660	(1,113)	18,708	19,839	(1,131)	(7.2%)	(6.0%)
Grand Total	**25,813**	**28,248**	**223,763**	**249,328**	**(25,564)**	**268,002**	**295,154**	**(27,152)**	**(11.4%)**	**(10.1%)**

Reserves Position

HCS is allocated additional funds each year based on business cases approved by GoJ/COM that are targeted towards specific projects and initiatives for improving the quality of care delivered. This funding is non-recurrent and is provided on a case-by-case basis each year.

It should be noted that unlike traditional budget funding models where contingency budgets are often held by individual organisations or departments, GoJ policy is to hold any reserves centrally in Treasury with individual organisations/departments applying for funding based on need. Therefore, contingency reserves are held centrally and not accumulated at organisation/department level.

The year-end forecast reserves after accounting for further forecast expenditure of £5.9m to year-end is £1.67m, made-up as follows:

- Growth Reserves £0.54m
- Covid Reserves £1.13m
- Capital Reserves £ nil

Forecast Risks

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

- Tertiary Care contracts relating to activity volumes.
- Mental Health placements and Social Care packages due to price variations
- Delays in substantive recruitment to replace agency staff and further extension of agency/locums
- Insufficient headroom to mitigate further cost pressures.

Movement in Agency vs Substantive Costs

The below table shows the net vacancy and agency position. This shows vacancies increasing by 17 in Mental Health and 9 in Surgical Services offset by reductions across a number of other areas. Agency numbers have dropped by 13. The forecast expenditure on agency staffing has remained consistent with September's forecast, with increases in Medical Director and Intermediate Care offset by reductions in Medical Services, Primary Care, Surgical Services, and Jersey Care Model.

Care Group	August Vacancy	September Vacancy	October Vacancy	Difference	August Vacancy covered by Agency	September Vacancy covered by Agency	October Vacancy covered by Agency	Difference	August Vacancy NOT covered by Agency	September Vacancy NOT covered by Agency	October Vacancy NOT covered by Agency	Difference	August Agency Forecast	September Agency Forecast	October Agency Forecast	Difference
	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	Amount (£)	Amount (£)	Amount (£)	Amount (£)
Chief Nurse	16	21	17	4	2	3	3	0	14	18	14	4	251,257	362,105	346,442	15,663
Director General's Office - HCS	12	25	12	13	0	0	0	0	12	25	12	13	1,097,085	1,104,735	1,104,735	1
Estates & Hard Facilities Management	9	7	5	2	0	0	0	0	9	7	5	2	0			0
Improvement & Innovation	8	8	3	5	0	0	0	0	8	8	3	5	0			0
Intermediate Care	5	1	2	-1	2	1	1	0	3	0	1	-1	179,588	179,588	289,387	-109,800
Jersey Care Model	0	2	2	1	0	0	0	0	0	2	2	1	295,256	295,256	213,000	82,256
Medical Director	27	27	26	1	4	5	5	0	23	22	21	1	420,268	420,268	580,463	-160,195
Medical Services	76	76	78	-2	59	39	38	1	17	37	40	-3	7,034,424	7,542,248	7,414,799	127,449
Mental Health	125	100	117	-17	40	33	30	3	85	67	87	-20	4,158,331	4,369,401	4,388,512	-19,111
Non-Clinical Support Services	37	27	34	-7	1	0	0	0	36	27	34	-7	0	0	0	0
Primary Care & Prevention	36	28	24	4	18	10	9	1	18	18	15	3	1,150,570	1,300,974	1,184,869	116,105
Social Care	32	36	32	4	3	2	3	-1	29	34	29	5	209,716	209,716	183,259	26,457
Surgical Services	86	69	78	-9	52	44	36	8	34	25	42	-17	6,920,097	6,720,415	6,669,159	51,256
Women Children & Family Care	48	45	42	3	24	18	17	1	24	27	26	1	3,375,328	3,553,325	3,525,126	28,199
Grand Total	516	472	473	-1	205	155	142	13	311	317	332	-15	25,091,920	26,058,031	25,899,752	158,279

4. Financial Recovery Plan (FRP)

M10 Progress Update

The FRP schemes identified as at M9 are £28m with a risk-adjusted value of £20m which are phased to be delivered over FY23 £3m, FY24 £12m and FY25 £10m. See table below.

GoJ FRP Project Plans Development Summary

All checks okay			Total Savings	Investment	Net Annualised	FY23	FY24	FY25	Total Risk	In Year Risk	RAG
Item	Workstreams	Projects	Identified FYI	Required	Amount	Identified Savings	Identified Savings	Identified Savings	Adj Amount	Adj Amount	Staus
	Clinical Productivity	Patient Flow and Discharge/LOS	1,111	46	**1,064**	-	500	500	1,072	-	
		Theatres Efficiency	3,084	-	**3,084**	-	2,449	636	3,084	-	
	Workforce	Clinical - Medical	2,748	-	**2,748**	120	1,689	735	2,057	-	
		Clinical - Nursing	3,949	-	**3,949**	-	1,916	2,033	2,567	-	
		Clinical - AHPs	1,945	-	**1,945**	-	1,294	615	1,264	-	
		Non-Clinical/ Directorate	1,840	-	**1,840**	-	920	920	1,196	-	
		Workforce Savings	1,190	-	**1,190**	30	160	-	440	-	
		Service Development	-	163	**-163**	-	-	-	-	-	
	Non-Pay and Procurement	Medicines Management	1,363	-	**1,363**	98	-	-	418	-	
		Procurement	3,085	70	**3,015**	585	2,163	266	2,278	-	
		Other Non-Pay	457	-	**457**	-	1,009	700	286	-	
		Non-Pay Controls (NPCP)	293	-	**293**	113	180	-	293	-	
		Theatres Efficiency	20	-	**20**	-	-	-	5	-	
	Income	Other Income Opportunities	2,351	100	**2,251**	184	1,872	-	2,031	-	
		Private Patients	1,941	-	**1,941**	184	368	-	557	-	
		Service Development	200	-	**200**	-	-	-	50	-	
		Mental Health	-	-	-	-	-	-	-	-	
		Social Care	600	-	**600**	-	-	-	150	-	
	Other Care group schemes	Patient Flow and Discharge/LOS	-	-	-	-	-	-	-	-	
		Clinical - Medical	-	-	-	-	-	-	-	-	
	IT & Digital Health	EPR	-	-	-	-	-	-	-	-	
Care Group and Directorate Schemes											
	Care Groups and Non-Clinical Directorate schemes	£3m in 3 months	2,035	-	**2,035**	2,008	-	-	1,997	28	
TOTAL EFFICIENCY SAVINGS			**28,209**	**379**	**27,830**	**3,321**	**14,520**	**6,405**	**19,744**	**28**	
Target			**35,000**			**3,000**	**16,000**	**16,000**			
Variance			**(6,791)**			**321**	**(1,480)**	**(9,595)**			

- The immediate priority is to deliver the in-year savings target of £3m by the year end requiring a challenging run-rate reduction of £1m per month over 3m Oct-Dec-23. £3.3m savings have been identified vs the £3m target by the Care Groups supported by the newly established Programme Management and Delivery Team (PMDT). £0.6m has been delivered in M10 with the remaining £2.6m savings forecast over Nov-Dec-23 to year end.

Care Group / Group	2023 Target £000	2023 Schemes Identified £000
Surgical Services	678	525
Medical Services	733	420
Chief Nurse	72	404
Primary Care & Prevention	134	361
Social Care	168	
Mental Health	371	
Women Children & Family	276	229
Medical Director	113	
Estates and Facilities	62	
Intermediate Care	52	
Jersey Care Model	36	
Improvement and Innovation	27	
Non-Clinical Support Services	278	193
Sub Total by Care Group	**3,000**	**2,132**
Cross-cutting Schemes		
Clinical – Medical Agency		120
Workforce Savings (AHP's)		30
Medicines Management		98
Procurement (Accommodation)		585
Non-Pay Controls		113
Private Patients Income		185
Total 2023 Target/ Savings Identified	**3,000**	**3,353**

Budget Planning FY24

The budget planning is process which started in October has been progressing at pace. There are significant challenges in completing budgets to meet the year-end deadline due to the complexity of the challenges to fit the funding within the budget available starting from the deficit position driven by identified cost pressures and overspends which historically has resulted in a sub-optimal allocation of resources and funding. Re-balancing to correct this requires making decisions on the optimal allocation and re-allocation of funding based on priority of service needs which will take a number of budget iterations to resolve.

5. Recommendation

The Board is asked to note:

- The FY23 year-end forecast improvement from a deficit of £29m to £27.2m due to a reduction in the underlying monthly run-rate overspend.
- Progress against the FY23 £3m savings target to achieve a £26m deficit position in line with the FRP Plan as agreed with Treasury.
- The monthly headline run-rate reduction to £2.4m as at M10 with a further forecast improvement to £0.8m per month for the remaining 2 months of the year, due to the impact of further FRP savings delivery and the planned use of reserves to further mitigate the overspend position this year.
- Risks to the year-end forecast include delays in substantive recruitment to replace agency staff and further extension of agency/locums, tertiary care contracts increased activity, Mental Health placements and Social Care packages due to price variation, and additional substantive recruitment with delayed agency displacement.
- The reserves position is forecast to be £1.67m by year-end.
- Budget Planning for FY24 has been progressing at pace but there are significant challenges in completing budgets to meet the year-end deadline due to the complexity of re-balancing budgets, based on priority of service needs, to correct the historical sub-optimal allocation of resources and funding which will take several budget iterations to resolve.

Health and Community Services

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FRP Programme Progress Update M10 Oct-23

Board
6 December 2023
Obi Hasan

Health and Community Services

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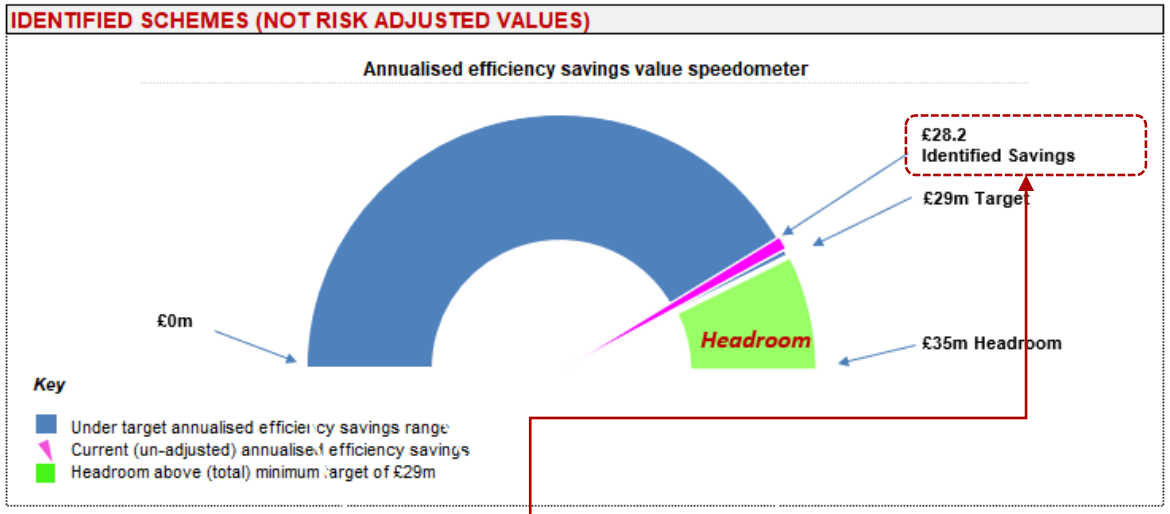
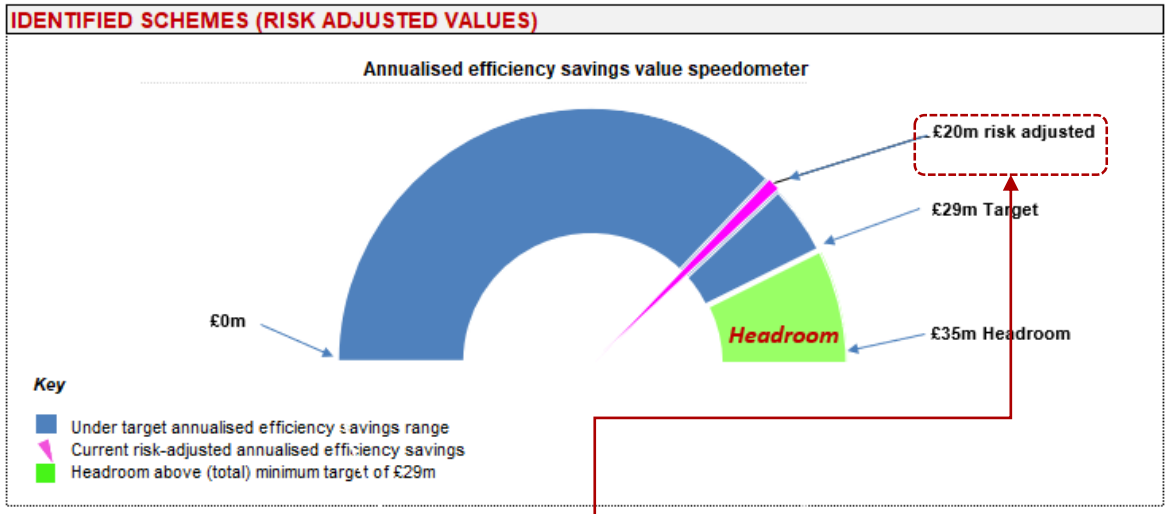
FRP Current Position

FRP Dashboard overview – at a glance

Total schemes identified as at **27th November are £28.2m**. Based on risk adjustment criteria reflecting the maturity of each scheme, the overall risk adjusted schemes have a value of **£20m**. Of the gross £28.2m, in-year benefits identified are **£3.3m**.





Annualised efficiency savings equate to c**£28.2m** (across **66** schemes).
N.b., these schemes are at various stages of development, hence the requirement to also analyse them on a risk adjusted basis – see adjacent table.

Annualised efficiency savings on a risk adjusted basis (i.e., adjusting the value for the level of confidence to delivery) equate to c**£20m** (across **66** schemes).

£'m								
FY23 Target	FY23 to date	Variance	FY24 Target	FY24 to date	Variance	FY25 Target	FY25 to date*	Variance*
3.0	3.3	0.3	16.0	14.9	(1.1)	16.0	6.0	(10.0)

**phasing of FY25 schemes currently in progress*

FY23 Savings Delivery - '£3m in 3 months'

Care Group / Group	2023 Target £000	2023 Schemes Identified £000
Surgical Services	678	525
Medical Services	733	420
Chief Nurse	72	404
Primary Care & Prevention	134	361
Social Care	168	
Mental Health	371	
Women Children & Family	276	229
Medical Director	113	
Estates and Facilities	62	
Intermediate Care	52	
Jersey Care Model	36	
Improvement and Innovation	27	
Non-Clinical Support Services	278	193
Sub Total by Care Group	**3,000**	**2,132**
Cross-cutting Schemes		
Clinical – Medical Agency		120
Workforce Savings (AHP's)		30
Medicines Management		98
Procurement (Accommodation)		585
Non-Pay Controls		113
Private Patients Income		185
Total 2023 Target/ Savings Identified	**3,000**	**3,353**

- The immediate priority is to deliver the FY23 in-year savings target of £3m by the year end requiring a challenging run-rate reduction of £1m per month over 3m Oct-Dec-23.
- Work has been progressing at pace with the Care Groups and Directorates supported by the newly established Programme Management and Delivery Team (PMDT).
- £3.2m savings have been identified vs the £3m target.
- £0.6m delivered in M10 with the remaining £2.6m savings forecast over Nov-Dec-23 to year end.

FRP Schemes in Delivery

24 schemes to date are in delivery, with an estimated in-year profiled saving of £3.2m, there are additional initiatives due to start delivery in December

GoJ FRP Project Plans In Delivery Summary

24-Nov-23
All checks okay

Item	Workstreams	Projects	Target	FY23 In-year plan	YTD Plan	YTD Delivery	FY23 YTD Variance	YTD Risk RAG	FY23 Adj Forecast	FY23 Adj Variance	Forecast Risk RAG	FY24 Plan
				FY23								FY24
Cross-cutting Schemes												
3	Workforce	Clinical - Medical	-	120	60	60	-		120	60		103
4	Non-Pay and Procuremen	Medicines Management	-	98	66	66	0		98	-		-
		Procurement	-	585	390	390	-		585	-		195
		Non-Pay Controls (NPCP)	-	113	39	-	-39		113	73		180
5	Income	Other Income Opportunities	-	184	-	-	-	-	184	184	-	1,172
		Private Patients	-	184	46	29	-17		184	138		368
Care Group and Directorate Schemes												
7	Care Groups and Non-Clinical Directorate schemes	£3m in 3 months	-	1,929	-	-	-	-	1,929	1,929	-	-
TOTAL EFFICIENCY SAVINGS			3,000	3,242	601	545	-56		3,242	2,384		2,178

Relates to Medicines Management - Switching to biosimilars - Paliperidone, Etanercept and Bevacizumab

Relates to non-pay procurement controls hotel accommodation, rationalisation of suppliers, Managed Inventory storage rationalisation, large contracts review

Relates to Medical locums conversion to substantive (x3)

Details shown in slide £3m in 3 months - Delivery

Showing unachieved whilst we develop a methodology to report on non-pay control initiative achievement (taxi's, stationary, meeting catering etc)

Health and Community Services

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FRP Dashboard: overview of FRP

FRP Schemes At A Glance

GoJ FRP Project Plans Development Summary

All checks okay

Item	Workstreams	Projects	Total Savings Identified FYI	Investment Required	Net Annualised Amount	FY23 Identified Savings	FY24 Identified Savings	FY25 Identified Savings	Total Risk Adj Amount	In Year Risk Adj Amount	RAG Staus
	Clinical Productivity	Patient Flow and Discharge/LOS	1,111	46	**1,064**	-	500	500	1,072	-	
		Theatres Efficiency	3,084	-	**3,084**	-	2,449	636	3,084	-	
	Workforce	Clinical - Medical	2,748	-	**2,748**	120	1,689	735	2,057	-	
		Clinical - Nursing	3,949	-	**3,949**	-	1,916	2,033	2,567	-	
		Clinical - AHPs	1,945	-	**1,945**	-	1,294	615	1,264	-	
		Non-Clinical/ Directorate	1,840	-	**1,840**	-	920	920	1,196	-	
		Workforce Savings	1,190	-	**1,190**	30	160	-	440	-	
		Service Development	-	163	**-163**	-	-	-	-	-	
	Non-Pay and Procurement	Medicines Management	1,363	-	**1,363**	98	-	-	418	-	
		Procurement	3,085	70	**3,015**	585	2,163	266	2,278	-	
		Other Non-Pay	457	-	**457**	-	1,009	700	286	-	
		Non-Pay Controls (NPCP)	293	-	**293**	113	180	-	293	-	
		Theatres Efficiency	20	-	**20**	-	-	-	5	-	
	Income	Other Income Opportunities	2,351	100	**2,251**	184	1,872	-	2,031	-	
		Private Patients	1,941	-	**1,941**	184	368	-	557	-	
		Service Development	200	-	**200**	-	-	-	50	-	
		Mental Health	-	-	-	-	-	-	-	-	
		Social Care	600	-	**600**	-	-	-	150	-	
	Other Care group schemes	Patient Flow and Discharge/LOS	-	-	-	-	-	-	-	-	
		Clinical - Medical	-	-	-	-	-	-	-	-	
	IT & Digital Health	EPR	-	-	-	-	-	-	-	-	
Care Group and Directorate Schemes											
	Care Groups and Non-Clinical Directorate schemes	£3m in 3 months	2,035	-	**2,035**	2,008	-	-	1,997	28	
TOTAL EFFICIENCY SAVINGS			**28,209**	**379**	**27,830**	**3,321**	**14,520**	**6,405**	**19,744**	**28**	
Target			**35,000**			**3,000**	**16,000**	**16,000**			
Variance			**(6,791)**			**321**	**(1,480)**	**(9,595)**			

Remaining gap to £35m 3yr stretch Target

FY24 and FY25 scheme phasing still being profiled hence the FY23, FY24 and FY25 figures will not yet add up to the total savings identified of ~£28m

[1] *Reflecting the current stage of development of detailed plans and confidence in delivery*

The estimated value of schemes that have been quantified is ~£28m (from 66 schemes) with a risk adjusted value of FYE savings of ~£20m made up of:

- 35 in the **Idea Only** stage at an annualised efficiency saving of £1.8m (£0 on a risk adjusted basis[1]);
- 19 in the **scoping** phase at an annualised efficiency saving of £2.2m (£0.6m on a risk adjusted basis[1]);
- 24 in the **In Progress** stage (equivalent total £13m annualised efficiency savings, £9m on a risk adjusted basis); and
- 5 are **Ready** (amounting to £4.6m annualised efficiency savings)
- 30 schemes have also entered the **Delivery Phase**. The full year savings are £5.6m and the in-year delivery forecast is £3.3m.

Health and Community Services

Gouvèrnément d'Jèrri

Programme Risks

Programme Risks

Risks	Mitigation	Support required from FRG?
1. Delivery of £3m of FRP savings in-year with 3m remaining	• PMDT support	• Deliver savings
2. Workforce workstream: • Recruitment pipeline progress to displace agency starting Jan-24 as per FRP Workforce workstream trajectory	• PMDT support	• Obtain recruitment pipeline progress tracking reports and unblocking any obstacles to delivery
3. Patient Flow and Discharges workstream: • Substantiating AAU and Corbiere 21 beds and recruitment of substantive staff to displace agency • Establishing 18 additional beds in Plemont to release surgical beds capacity	• PMDT support	• Obtain recruitment pipeline progress tracking reports and unblocking any obstacles to delivery
4. Theatres efficiency workstream: • Establishing clinic templates at consultant level and ensuring booking of lists to deliver improved throughput measured by KPI of average cases per list (ACPL) as per agreed FRP trajectory.	• PMDT support	• Remove any obstacles to delivery

Treasury and Exchequer

HCS Finance Report M10 October 2023

O Hasan / M Queree

Gouvèrnément d'Jèrri

Executive Summary – Month 10

The Year-to-date actual vs budget overspend has increased by £2.5m in M10 to £25.6m, showing a slowing down of £0.2m in the underlying monthly run-rate. The FY23 year-end forecast has reduced to a deficit of £27.2m, with the forecast run rate reducing by £0.7m to an exit run-rate by year end of £1.7m overspend.

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
HCS Categorisation	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Staff Costs	19,947	20,993	161,829	171,583	(9,754)	197,014	207,021	(10,007)	(6.0%)	(5.1%)
Non Pay	8,012	10,112	82,977	98,949	(15,972)	97,195	114,819	(17,624)	(19.2%)	(18.1%)
Income	(2,146)	(2,857)	(21,043)	(21,205)	162	(26,207)	(26,686)	479	0.8%	1.8%
Grand Total	25,813	28,248	223,763	249,328	(25,564)	268,002	295,154	(27,152)	(11.4%)	(10.1%)

The key drivers are:

Year-to-date (YTD) position £25.6 m deficit:

- **Staff Costs £9.8m overspend** which includes £3.9m of opening budget pressure re agency/locum costs, a further £23.0m agency/locum overspend (191 FTE – 142 covering vacancies, 49 other), and £3.2m of overtime costs, which are substantially mitigated by underspends of £20.3m in substantive staffing due to vacant posts (473 FTE) across other Care Groups/Directorates. The underlying factors driving these cost pressures are recruitment issues, dependency on temporary staffing, expansion/escalation beds, and loss in productivity since 2019. The main Care Groups/Directorates accounting for this overspend are Medical Services £8.6m, Surgical Services £2.9m, and Women and Children £1.4m.
- **Non-Pay £16.0m overspend** which includes £6.7m part-year effect of the opening pressure with the remaining £9.3m overspend driven by capacity and activity pressures in Mental Health on off-Island placements and drugs £2.8m, Chief Nurse re Accommodation Service £1.2m (due to due accommodation costs exceeding rental income), Surgical Services £1.2m in relation to medical supplies and consumables in Theatres, Day Surgery Unit and Radiology, and Social Care on domiciliary care packages £1.0m. Other cost pressures are in Medical Director £0.9m, Medical Services £0.7m, Non-Clinical Support Services £0.6m, of which the majority relates to increased patient travel costs and Estates compliance works, and Estates & Hard FM maintenance works £0.6m.
- **Income over-achievement £0.2m** due to Surgical Services private patient income underperformance of £1.9m offset by overachievements in Chief Nurse £0.8m from additional staff accommodation, and Mental Health £0.4m and Intermediate Care £0.3m in relation to Long Term Care Benefit.

FY23 year-end forecast £27.2m deficit:

- **Staff Costs are forecast to overspend by £10.0m** which includes an element of the opening pressure of £4.7m, £24.0m overspend on agency locums (191 FTE), partially mitigated by an £18.7m underspend on substantive staffing due to vacancies (473 FTE).
- The net impact above is made-up of agency/locums cost overspends in Medical Services £7.0m, Surgical Services £6.3m, Mental Health £4.4m, Women and Children Services £3.4m, Primary Care £1.2m, Medical Director £0.6m, Chief Nurse £0.3m, Intermediate Care £0.3m, and Jersey Care Model £0.2m, which are mitigated by substantive pay underspends of £18.7m due to vacancies in Mental Health £5.7m, Surgical Services £3.8m, Women & Children & Family Care £2.1m, Primary Care & Prevention £2.1m, Medical Director £1.6m, Chief Nurse £1.3m, Non-Clinical Support Services £0.8m, Estates & Hard FM £0.5m, Jersey Care Model £0.5m, Social Care £0.2m, and Improvement & Innovation £0.2m. The exception is Medical Services with a substantive pay forecast overspend of £2.6m.
- The month-on-month movement is a forecast decrease of £1.2m, driven by an agency expenditure forecast decrease of £0.4m, and a £0.8m reduction in substantive staffing spend.
- The forecast includes expected receipts of two additional pay related funding items of £2.2m from Treasury.

Executive Summary – Month 10 (cont.)

Non-Pay overspend £17.6m of which £9.2m relates to the opening budget pressure, with the remaining £8.4m spread across Care Groups, with Mental Health £3.2m, Surgical Services £1.6m, Chief Nurse £1.6m, Social Care £1.5m, Tertiary Care £1.3m, Non-Clinical Support Services £1.0m, Estates £0.6m, Jersey Care Model £0.4m, and Medical Director £0.2m.

Income over-achievement £0.5m is due to the under-performance in Surgery private patient income of £2.7m due to a lack of surgical beds capacity which is offset by over-performance in Chief Nurse £1.2m, Mental Health £0.7m, Intermediate Care £0.5m, Social Care £0.4m, Women and Children and Non-Clinical Support Services both £0.2m.

Financial Position By Care Group/Directorate:

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Care Groups & Directorates	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	936	612	5,890	5,387	504	6,604	6,094	510	8.6%	7.7%
Director General's Offic	(24)	582	(377)	7,029	(7,406)	1,149	9,001	(7,852)	(1,962.0%)	683.6%
Estates & Hard Facilitie	747	997	9,174	9,315	(141)	10,669	10,783	(114)	(1.5%)	(1.1%)
Improvement & Innovation	1,627	2,278	15,436	15,245	191	18,183	18,055	128	1.2%	0.7%
Intermediate Care	250	247	1,804	1,634	171	2,058	1,999	58	9.5%	2.8%
Jersey Care Model	433	365	4,328	4,705	(377)	5,193	5,392	(198)	(8.7%)	(3.8%)
Medical Director	785	1,093	7,632	7,119	514	9,168	8,220	948	6.7%	10.3%
Medical Services	5,442	7,163	46,156	55,646	(9,490)	55,186	65,282	(10,096)	(20.6%)	(18.3%)
Mental Health	3,345	3,475	27,356	29,053	(1,697)	32,840	33,967	(1,127)	(6.2%)	(3.4%)
Non-Clinical Support Ser	1,884	1,487	18,845	18,562	283	22,614	22,584	30	1.5%	0.1%
Primary Care & Preventio	905	804	8,694	8,140	554	9,982	9,124	858	6.4%	8.6%
Social Care	2,059	1,980	17,849	18,963	(1,113)	21,061	22,124	(1,063)	(6.2%)	(5.0%)
Surgical Services	4,377	4,633	34,762	40,799	(6,037)	41,789	48,618	(6,829)	(17.4%)	(16.3%)
Tertiary Care	1,067	630	10,666	11,072	(406)	12,799	14,072	(1,273)	(3.8%)	(9.9%)
Women Children & Family	1,979	1,903	15,546	16,660	(1,113)	18,708	19,839	(1,131)	(7.2%)	(6.0%)
Grand Total	**25,813**	**28,248**	**223,763**	**249,328**	**(25,564)**	**268,002**	**295,154**	**(27,152)**	**(11.4%)**	**(10.1%)**

*Note: For detailed break-down see Appendices - slides 10-11 for Pay Position, slide 12 for Non-Pay Position, and slide 13 for Income Position.

Executive Summary – Month 10 (cont.)

Reserves Position

HCS is allocated additional funds each year based on business cases approved by GoJ/COM that are targeted towards specific projects and initiatives for improving the quality of care delivered. This funding is non-recurrent and is provided on a case-by-case basis each year.

It should be noted that unlike traditional budget funding models where contingency budgets are often held by individual organisations or departments, GoJ policy is to hold any reserves centrally in Treasury with individual organisations/departments applying for funding based on need. Therefore, contingency reserves are held centrally and not accumulated at organisation/department level.

The year-end forecast reserves after accounting for further forecast expenditure of £5.9m to year-end is £1.67m, made-up as follows:

- Growth Reserves £0.54m
- Covid Reserves £1.13m
- Capital Reserves £ nil

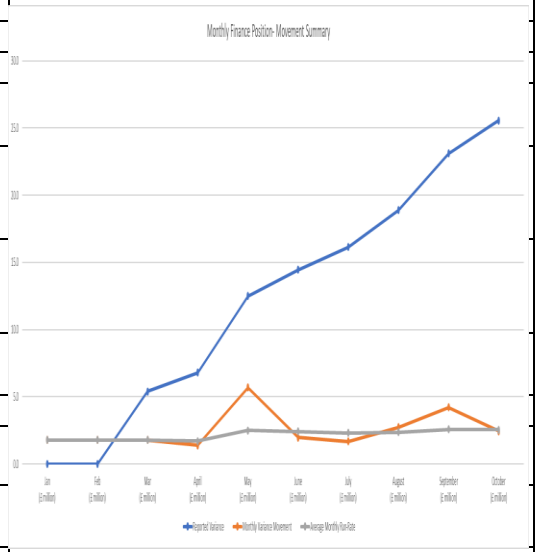
Forecast Risks

- Tertiary Care contracts relating to activity volumes.
- Mental Health placements and Social Care packages due to price variations
- Delays in substantive recruitment to replace agency staff and further extension of agency/locums
- Insufficient headroom to mitigate further cost pressures.

Run Rate Analysis

Year-to-date average run rate has remained at £2.6m overspend per month but the underlying monthly run-rate shows a reduction to £2.4m. The projected monthly overspend for the last 2 months of the year is forecast to reduce to just under £0.8m. This includes the expected receipts of two additional pay related funding items of £2.2m accounting for a monthly run-rate impact of £1.1m.

Monthly Finance Position	Jan (£ million)	Feb (£ million)	Mar (£ million)	April (£ million)	May (£ million)	June (£ million)	July (£ million)	August (£ million)	September (£ million)	October (£ million)	Nov-Dec (£ million)	Full Year 2023 (£ million)	Explanation
Reported Variance			(5.40)	(6.80)	(12.50)	(14.46)	(16.14)	(18.88)	(23.10)	(25.56)			
Monthly Variance Movement	(1.80)	(1.80)	(1.80)	(1.40)	(5.70)	(1.96)	(1.68)	(2.74)	(4.22)	(2.46)			
Average Monthly Run-Rate	(1.80)	(1.80)	(1.80)	(1.70)	(2.50)	(2.41)	(2.31)	(2.36)	(2.57)	(2.56)			
Adjustments:													
Drugs interface not posted month 4				(1.40)	1.40								
Surgical Services private patient income- reviewed income expectations	(0.14)	(0.14)	(0.14)	(0.14)	0.56								
Non Clinical Support Services- postage and patient travel expenditure processing delays	(0.14)	(0.14)	(0.14)	(0.14)	0.56								
Tertiary Care- variability in payment profile	(0.10)	(0.10)	(0.10)	(0.10)	0.40								
Social Care- catch-up on domiciliary care packages expenditure and Les Amis	(0.10)	(0.10)	(0.10)	(0.10)	0.40								
Accounts receivable error							(0.70)	0.70					
Stamp Duty accounting error								1.30	(1.30)				
Operation Crocus										1.08	0.22		
Parental Leave										0.71	0.14		
Adjusted Variance	(2.28)	(2.28)	(2.28)	(3.28)	(2.38)	(1.96)	(2.38)	(0.74)	(5.52)	(0.67)			
Year to Date Cumulative Variance	(2.28)	(4.56)	(6.84)	(10.12)	(12.50)	(14.46)	(16.84)	(17.58)	(23.10)	(23.77)	(3.38)	(27.15)	
Underlying run-rate	(2.28)	(2.28)	(2.28)	(2.53)	(2.50)	(2.41)	(2.41)	(2.20)	(2.57)	(2.38)	(1.69)	(2.26)	



Substantive vs Agency

The below table shows the net vacancy and agency position. This shows vacancies increasing by 17 in Mental Health and 9 in Surgical Services offset by reductions across a number of other areas. Agency numbers have dropped by 13. The forecast expenditure on agency staffing has remained consistent with September's forecast, with increases in Medical Director and Intermediate Care offset by reductions in Medical Services, Primary Care, Surgical Services, and Jersey Care Model.

	August	September	October		August	September	October		August	September	October		August	September	October	
Care Group	Vacancy	Vacancy	Vacancy	Difference	Vacancy covered by Agency	Vacancy covered by Agency	Vacancy covered by Agency	Difference	Vacancy NOT covered by Agency	Vacancy NOT covered by Agency	Vacancy NOT covered by Agency	Difference	Agency Forecast	Agency Forecast	Agency Forecast	Difference
	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	Amount (£)	Amount (£)	Amount (£)	Amount (£)
Chief Nurse	16	21	17	**4**	2	3	3	**0**	14	18	14	4	251,257	362,105	346,442	15,663
Director General's Office - HCS	12	25	12	**13**	0	0	0	**0**	12	25	12	13	1,097,085	1,104,735	1,104,735	1
Estates & Hard Facilities Management	9	7	5	**2**	0	0	0	**0**	9	7	5	2	0			0
Improvement & Innovation	8	8	3	**5**	0	0	0	**0**	8	8	3	5	0			0
Intermediate Care	5	1	2	**-1**	2	1	1	**0**	3	0	1	-1	179,588	179,588	289,387	-109,800
Jersey Care Model	0	2	2	**1**	0	0	0	**0**	0	2	2	1	295,256	295,256	213,000	82,256
Medical Director	27	27	26	**1**	4	5	5	**0**	23	22	21	1	420,268	420,268	580,463	-160,195
Medical Services	76	76	78	**-2**	59	39	38	**1**	17	37	40	-3	7,034,424	7,542,248	7,414,799	127,449
Mental Health	125	100	117	**-17**	40	33	30	**3**	85	67	87	-20	4,158,331	4,369,401	4,388,512	-19,111
Non-Clinical Support Services	37	27	34	**-7**	1	0	0	**0**	36	27	34	-7	0	0	0	0
Primary Care & Prevention	36	28	24	**4**	18	10	9	**1**	18	18	15	3	1,150,570	1,300,974	1,184,869	116,105
Social Care	32	36	32	**4**	3	2	3	**-1**	29	34	29	5	209,716	209,716	183,259	26,457
Surgical Services	86	69	78	**-9**	52	44	36	**8**	34	25	42	-17	6,920,097	6,720,415	6,669,159	51,256
Women Children & Family Care	48	45	42	**3**	24	18	17	**1**	24	27	26	1	3,375,328	3,553,325	3,525,126	28,199
Grand Total	**516**	**472**	**473**	**-1**	**205**	**155**	**142**	**13**	**311**	**317**	**332**	**-15**	**25,091,920**	**26,058,031**	**25,899,752**	**158,279**

Financial Recovery Plan (FRP)

M10 Progress Update

- The FRP schemes identified as at M9 are £28m with a risk-adjusted value of £20m which are phased to be delivered over FY23 £3m, FY24 £12m and FY25 £10m. See table below.

GoJ FRP Project Plans Development Summary

All checks okay

Item	Workstreams	Projects	Total Savings Identified FYI	Investment Required	Net Annualised Amount	FY23 Identified Savings	FY24 Identified Savings	FY25 Identified Savings	Total Risk Adj Amount	In Year Risk Adj Amount	RAG Staus
	Clinical Productivity	Patient Flow and Discharge/LOS	1,111	46	**1,064**	-	500	500	1,072	-	
		Theatres Efficiency	3,084	-	**3,084**	-	2,449	636	3,084	-	
	Workforce	Clinical - Medical	2,748	-	**2,748**	120	1,689	735	2,057	-	
		Clinical - Nursing	3,949	-	**3,949**	-	1,916	2,033	2,567	-	
		Clinical - AHPs	1,945	-	**1,945**	-	1,294	615	1,264	-	
		Non-Clinical/ Directorate	1,840	-	**1,840**	-	920	920	1,196	-	
		Workforce Savings	1,190	-	**1,190**	30	160	-	440	-	
		Service Development	-	163	**-163**	-	-	-	-	-	
	Non-Pay and Procurement	Medicines Management	1,363	-	**1,363**	98	-	-	418	-	
		Procurement	3,085	70	**3,015**	585	2,163	266	2,278	-	
		Other Non-Pay	457	-	**457**	-	1,009	700	286	-	
		Non-Pay Controls (NPCP)	293	-	**293**	113	180	-	293	-	
		Theatres Efficiency	20	-	**20**	-	-	-	5	-	
	Income	Other Income Opportunities	2,351	100	**2,251**	184	1,872	-	2,031	-	
		Private Patients	1,941	-	**1,941**	184	368	-	557	-	
		Service Development	200	-	**200**	-	-	-	50	-	
		Mental Health	-	-	**-**	-	-	-	-	-	
		Social Care	600	-	**600**	-	-	-	150	-	
	Other Care group schemes	Patient Flow and Discharge/LOS	-	-	-	-	-	-	-	-	
		Clinical - Medical	-	-	-	-	-	-	-	-	
	IT & Digital Health	EPR	-	-	-	-	-	-	-	-	
Care Group and Directorate Schemes											
	Care Groups and Non-Clinical Directorate schemes	£3m in 3 months	2,035	-	**2,035**	2,008	-	-	1,997	28	
TOTAL EFFICIENCY SAVINGS			**28,209**	**379**	**27,830**	**3,321**	**14,520**	**6,405**	**19,744**	**28**	

Target	35,000		3,000	16,000	16,000
Variance	(6,791)		321	(1,480)	(9,595)

Financial Recovery Plan (FRP)

M10 Progress Update

- The immediate priority is to deliver the in-year savings target of £3m by the year end requiring a challenging run-rate reduction of £1m per month over 3m Oct-Dec-23. £3.3m savings have been identified vs the £3m target by the Care Groups supported by the newly established Programme Management and Delivery Team (PMDT). £0.6m has been delivered in M10 with the remaining £2.6m savings forecast over Nov-Dec-23 to year end.

Care Group / Group	2023 Target £000	2023 Schemes Identified £000
Surgical Services	678	525
Medical Services	733	420
Chief Nurse	72	404
Primary Care & Prevention	134	361
Social Care	168	
Mental Health	371	
Women Children & Family	276	229
Medical Director	113	
Estates and Facilities	62	
Intermediate Care	52	
Jersey Care Model	36	
Improvement and Innovation	27	
Non-Clinical Support Services	278	193
Sub Total by Care Group	**3,000**	**2,132**
Cross-cutting Schemes		
Clinical – Medical Agency		120
Workforce Savings (AHP's)		30
Medicines Management		98
Procurement (Accommodation)		585
Non-Pay Controls		113
Private Patients Income		185
Total 2023 Target/ Savings Identified	**3,000**	**3,353**

Budget Planning FY24

- The budget planning is process which started in October has been progressing at pace.

- There are significant challenges in completing budgets to meet the year-end deadline due to the complexity of the challenges to fit the funding within the budget available starting from the deficit position driven by identified cost pressures and overspends which historically has resulted in a sub-optimal allocation of resources and funding. Re-balancing to correct this requires making decisions on the optimal allocation and re-allocation of funding based on priority of service needs which will take a number of budget iterations to resolve.

Summary and Conclusion - Month 10

- The YTD overspend is £25.6m. The FY23 year-end forecast has improved from a deficit of £29m to £27.2m due to a reduction in the underlying monthly run-rate overspend.
- Progress against the FY23 £3m savings target to achieve a £26m deficit position in line with the FRP Plan as agreed with Treasury. £3.3m savings have been identified vs the £3m target by the Care Groups supported by the newly established Programme Management and Delivery Team (PMDT). £0.6m has been delivered in M10 with the remaining £2.6m savings forecast over Nov-Dec-23 to year end.
- The monthly headline run-rate reduction to £2.4m as at M10 with a further forecast improvement to £0.8m per month for the remaining 2 months of the year, due to the impact of further FRP savings delivery and the planned use of reserves to further mitigate the overspend position this year.
- Risks to the year-end forecast include delays in substantive recruitment to replace agency staff and further extension of agency/locums, tertiary care contracts increased activity, Mental Health placements and Social Care packages due to price variation, and additional substantive recruitment with delayed agency displacement.
- The reserves position is forecast to be £1.67m by year-end.
- Budget Planning for FY24 has been progressing at pace but there are significant challenges in completing budgets to meet the year-end deadline due to the complexity of re-balancing budgets, based on priority of service needs, to correct the historical sub-optimal allocation of resources and funding which will take several budget iterations to resolve.

Treasury and Exchequer

Appendices

Gouvèrnément d'Jèrri

Summary Position by Care Groups/Directorates – Month 10

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Care Groups & Directorates	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	936	612	5,890	5,387	504	6,604	6,094	510	8.6%	7.7%
Director General's Offic	(24)	582	(377)	7,029	(7,406)	1,149	9,001	(7,852)	(1,962.0%)	683.6%
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Tertiary Care	1,067	630	10,666	11,072	(406)	12,799	14,072	(1,273)	(3.8%)	(9.9%)
Women Children & Family	1,979	1,903	15,546	16,660	(1,113)	18,708	19,839	(1,131)	(7.2%)	(6.0%)
Grand Total	**25,813**	**28,248**	**223,763**	**249,328**	**(25,564)**	**268,002**	**295,154**	**(27,152)**	**(11.4%)**	**(10.1%)**

Year-to-date overspend £25.6m (11.4%, adverse movement of £2.5m from September), made up of:

- **£9.8m overspend on Staff Costs- £20.3m underspend on Substantive staffing offset by £23.0m Agency plus £3.2m Overtime -** The position includes significant overspends in Medical Services £8.6m, Surgical Services £2.9m, and Women & Children & Family Care £1.4m, where agency usage and other temporary workforce has been used to cover vacant roles and staff absences. Offset by vacancy underspends across other areas.
- **£16.0m overspend on Non Pay-** which includes £6.7m part-year effect of the opening pressure with the remaining £9.3m overspend driven by scarce capacity and activity pressures in Mental Health on off-Island placements and drugs £2.8m, Chief Nurse re Accommodation Service £1.2m due to due to expansion of staff accommodation costs exceeding rental income (see accommodation income below), Surgical Services £1.2m in relation to medical supplies and consumables in Theatres, Day Surgery Unit and Radiology, and Social Care on domiciliary care packages £1.0m.
- **£0.2m overachievement of Income-** Surgical Services underperformance by £1.9m against private patient income targets. This is offset by overachievements in Chief Nurse £0.8m from additional staff accommodation capacity, and Mental Health £0.4m and Intermediate Care £0.3m in relation to Long Term Care Benefit.

Full-year forecast overspend £27.2m (10.1%, £1.8m reduction from September), made up of:

- **£10.0m overspend on Staff Costs** which includes £4.7m of opening pressure, £18.7m underspend on substantive staffing due to vacancies, offset with £24.0m on agency staffing. Significant forecast overspends in Medical Services £9.9m, Surgical Services £2.5m, and Women & Children £1.3m.
- **£17.6m overspend on Non Pay-** £9.2m relates to the opening budget pressure, with the remaining £8.4m spread across Care Groups, with Mental Health £3.2m, Surgical Services £1.6m, Chief Nurse £1.6m, Social Care £1.5m, Tertiary Care £1.3m, Non-Clinical Support Services £1.0m, Estates £0.6m, Jersey Care Model £0.4m, and Medical Director £0.2m.
- **£0.5m overachievement of Income -** a Surgical Services private patient income under-recovery of £2.7m, offset by an over-recovery of Long-Term Care Benefit income and Accommodation income in Chief Nurse.

Pay Position – Month 10

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Subjective Category Detail	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Substantive	19,873	18,174	160,066	143,658	16,409	195,104	180,814	14,289	10.3%	7.3%
Agency	74	2,493	1,763	24,765	(23,002)	1,910	25,907	(23,997)	(1,305.0%)	(1,256.2%)
Recharges	0	0	0	11	(11)	0	260	(260)		
Overtime	0	327	0	3,150	(3,150)	0	40	(40)		
Grand Total	**19,947**	**20,993**	**161,829**	**171,583**	**(9,754)**	**197,014**	**207,021**	**(10,007)**		

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Care Groups & Directorates	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	581	571	4,717	3,824	893	5,670	4,729	940	18.9%	16.6%
Director General's Offic	552	435	2,182	3,782	(1,600)	5,219	7,277	(2,058)	(73.3%)	(39.4%)
Estates & Hard Facilitie	380	372	3,803	3,364	438	4,563	4,081	482	11.5%	10.6%
Improvement & Innovation	171	377	1,665	1,426	239	1,998	1,759	239	14.4%	12.0%
Intermediate Care	344	389	2,642	2,675	(34)	3,182	3,522	(339)	(1.3%)	(10.7%)
Jersey Care Model	204	23	2,044	2,250	(205)	2,453	2,213	240	(10.0%)	9.8%
Medical Director	761	706	7,389	6,058	1,331	8,875	7,844	1,031	18.0%	11.6%
Medical Services	4,200	5,268	32,717	41,349	(8,632)	39,261	49,117	(9,857)	(26.4%)	(25.1%)
Mental Health	2,810	2,723	21,965	21,244	721	26,400	25,040	1,360	3.3%	5.2%
Non-Clinical Support Ser	1,568	1,491	15,683	14,963	720	18,819	18,008	811	4.6%	4.3%
Primary Care & Preventio	814	711	7,789	7,115	674	9,349	8,443	906	8.6%	9.7%
Social Care	1,261	1,282	9,573	9,501	73	11,488	11,464	24	0.8%	0.2%
Surgical Services	4,449	4,633	35,396	38,324	(2,927)	42,567	45,034	(2,467)	(8.3%)	(5.8%)
Women Children & Family	1,851	2,011	14,264	15,709	(1,444)	17,169	18,490	(1,321)	(10.1%)	(7.7%)
Grand Total	**19,947**	**20,993**	**161,829**	**171,583**	**(9,754)**	**197,014**	**207,021**	**(10,007)**	**(6.0%)**	**(5.1%)**

Year-to-date overspend 9.8m (6.0%), made up of:

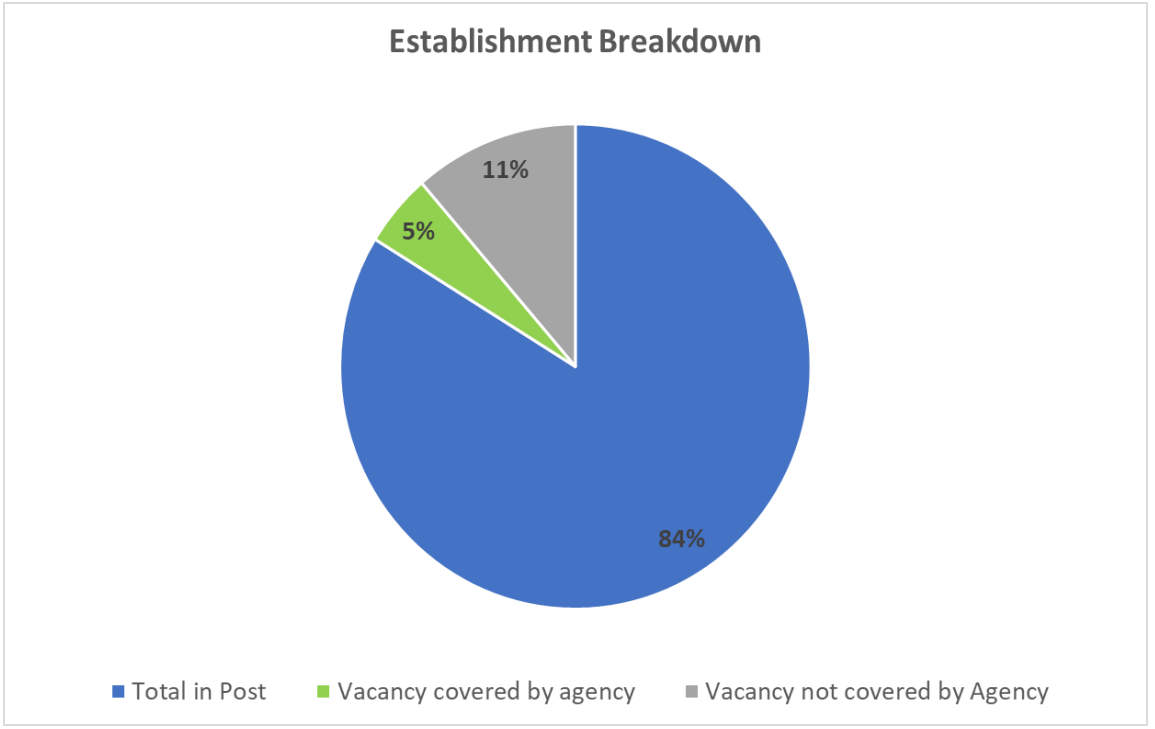
- **Opening Pressure £3.9m** apportioned to staffing
- **Substantive pay underspend of £20.3m** in respect of vacant posts totalling 470 FTE, mainly within Mental Health £5.7m, Surgical Services £3.8m, Medical Director £1.7m, Women & Children & Family Care £1.7m, Primary Care & Prevention £1.6m, Non-Clinical Support Services £1.6m, Chief Nurse £1.1m, Estates & Hard FM £0.7m, Improvement & Innovation and Social Care both £0.3m, Intermediate Care £0.2m, and Jersey Care Model £0.1m. There is an overspend of £0.8m on Medical Services.
- **Overtime spend of £3.2m**, with major spends in Non-Clinical Support Services £0.8million, Medical Services £0.7m, Surgical Services £0.5m, Mental Health £0.4m, Estates & Hard FM £0.3m, Women & Children's Services £0.2m, and Intermediate Care £0.1m.
- **Agency staffing overspend £23.0m**, with Medical Services £7.1m, Surgical Services £6.3m, Mental Health £4.5m, Women & Children's Services £2.9m, Primary Care £0.9m, Medical Director and Jersey Care Model both £0.3m, Chief Nurse and Social Care £0.2m, DG's Office and Non-Clinical Support £0.1m each.

Full year forecast overspend £10.0m (5.1%), made up of:

- **Opening Pressure £4.7m** apportioned to staffing
- **Substantive pay underspend of £18.7m (includes forecast of Zero Hours and Overtime)** in respect of vacant posts mainly within Mental Health £5.7m, Surgical Services £3.8m, Women & Children & Family Care £2.1m, Primary Care & Prevention £2.1m, Medical Director £1.6m, Chief Nurse £1.3m, Non-Clinical Support Services £0.8m, Estates & Hard FM £0.5m, Jersey Care Model £0.5m, Social Care and Improvement & Innovation both £0.2m. These are offset by a forecast overspend in Medical Services of £2.6m.
- **Agency staffing overspend £24.0m**, with Medical Services £7.0m, Surgical Services £6.3m, Mental Health £4.4m, Women & Children's Services £3.4m, Primary Care £1.2m, Medical Director £0.6m, Chief Nurse, Intermediate Care, Jersey Care Model and Social Care all £0.2m.

Vacancies– Month 10

Care Group	Staff Type	Total Budgeted FTE	Total in Post	Total Vacancy	Vacancy covered by Agency
Chief Nurse	AHP	2	2	0	0
Chief Nurse	Civil Servant & Associated	45	36	9	1
Chief Nurse	Manual Workers	7	6	1	0
Chief Nurse	Medical	0	0	0	0
Chief Nurse	Nurses & Midwives	23	16	7	2
Chief Nurse Total		**78**	**60**	**17**	**3**
Director General's Office - HCS	Civil Servant & Associated	34	22	12	0
Director General's Office - HCS	Manual Workers	0	0	0	0
Director General's Office - HCS	Medical	4	4	0	0
Director General's Office - HCS	Nurses & Midwives	0	0	0	0
Director General's Office - HCS Total		**38**	**26**	**12**	**0**
Estates & Hard Facilities Management	Civil Servant & Associated	10	10	0	0
Estates & Hard Facilities Management	Manual Workers	60	55	5	0
Estates & Hard Facilities Management Total		**70**	**65**	**5**	**0**
Improvement & Innovation	Civil Servant & Associated	30	27	3	0
Improvement & Innovation	Nurses & Midwives	1	1	0	0
Improvement & Innovation Total		**31**	**28**	**3**	**0**
Intermediate Care	Civil Servant & Associated	22	22	0	0
Intermediate Care	Nurses & Midwives	38	36	2	1
Intermediate Care Total		**60**	**57**	**2**	**1**
Jersey Care Model	Civil Servant & Associated	37	36	1	0
Jersey Care Model	Medical	4	4	0	0
Jersey Care Model	Nurses & Midwives	5	4	1	0
Jersey Care Model Total		**45**	**44**	**2**	**0**
Medical Director	AHP	52	42	10	5
Medical Director	Civil Servant & Associated	35	27	8	0
Medical Director	Medical	61	53	8	0
Medical Director	Nurses & Midwives	2	2	0	0
Medical Director Total		**150**	**123**	**26**	**5**
Medical Services	AHP	75	67	8	4
Medical Services	Civil Servant & Associated	41	34	7	0
Medical Services	Medical	79	75	4	8
Medical Services	Nurses & Midwives	332	273	59	26
Medical Services Total		**527**	**449**	**78**	**38**
Mental Health	AHP	5	5	0	0
Mental Health	Civil Servant & Associated	150	99	51	3
Mental Health	Medical	24	12	12	8
Mental Health	Nurses & Midwives	205	151	55	19
Mental Health Total		**384**	**267**	**117**	**30**
Non-Clinical Support Services	Civil Servant & Associated	144	126	18	0
Non-Clinical Support Services	Manual Workers	267	250	17	0
Non-Clinical Support Services Total		**410**	**376**	**34**	**0**
Primary Care & Prevention	AHP	99	79	20	7
Primary Care & Prevention	Civil Servant & Associated	27	25	2	1
Primary Care & Prevention	Medical	1	0	1	0
Primary Care & Prevention	Nurses & Midwives	10	9	1	0
Primary Care & Prevention Total		**137**	**113**	**24**	**9**
Social Care	AHP	10	10	0	0
Social Care	Civil Servant & Associated	74	65	9	2
Social Care	Manual Workers	2	2	0	0
Social Care	Nurses & Midwives	138	115	22	1
Social Care Total		**224**	**192**	**32**	**3**
Surgical Services	AHP	89	76	13	5
Surgical Services	Civil Servant & Associated	51	42	9	0
Surgical Services	Manual Workers	17	16	1	0
Surgical Services	Medical	71	63	8	6
Surgical Services	Nurses & Midwives	314	267	47	24
Surgical Services Total		**541**	**464**	**78**	**36**
Women Children & Family Care	AHP	29	25	3	1
Women Children & Family Care	Civil Servant & Associated	15	13	2	0
Women Children & Family Care	Medical	37	30	7	4
Women Children & Family Care	Nurses & Midwives	128	97	30	12
Women Children & Family Care Total		**208**	**166**	**42**	**17**
Grand Total		**2,905**	**2,432**	**470**	**142**



Non-Pay Position – Month 10

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Subjective Category Detail	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Supplies and Services	5,911	7,618	60,644	75,622	(14,978)	70,658	87,914	(17,256)	(24.7%)	(24.4%)
Drugs & Vaccinations	1,541	1,627	15,407	15,564	(156)	18,488	18,053	435	(1.0%)	2.4%
Premises & Maintenance	386	561	5,181	5,454	(273)	5,954	6,309	(355)	(5.3%)	(6.0%)
Clinical supplies	138	220	1,385	1,644	(259)	1,662	1,985	(323)	(18.7%)	(19.4%)
Administrative Expenses	23	60	228	602	(373)	274	457	(183)	(163.4%)	(66.7%)
Financial Adjustments & Write-	8	26	79	53	26	95	76	19	33.4%	20.0%
Social Benefit Payment	5	1	52	11	42	63	24	39	79.1%	62.0%
Grand Total	**8,012**	**10,112**	**82,977**	**98,949**	**(15,972)**	**97,195**	**114,819**	**(17,624)**	**0.0%**	**0.0%**

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Care Groups & Directorates	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	563	583	3,258	4,436	(1,177)	3,437	5,057	(1,621)	36.1%	47.2%
Director General's Offic	(566)	225	(2,461)	3,803	(6,263)	(3,952)	1,800	(5,752)	254.5%	145.5%
Estates & Hard Facilitie	367	625	5,375	5,964	(589)	6,110	6,715	(605)	(11.0%)	(9.9%)
Improvement & Innovation	1,456	1,901	13,771	13,819	(48)	16,185	16,296	(111)	(0.3%)	(0.7%)
Intermediate Care	6	15	63	195	(133)	75	166	(91)	(212.2%)	(121.7%)
Jersey Care Model	228	342	2,284	2,455	(171)	2,740	3,179	(438)	(7.5%)	(16.0%)
Medical Director	96	396	956	1,904	(948)	1,147	1,368	(221)	(99.1%)	(19.3%)
Medical Services	1,692	2,015	17,927	18,552	(626)	21,310	21,421	(111)	(3.5%)	(0.5%)
Mental Health	555	799	5,571	8,414	(2,843)	6,680	9,838	(3,158)	(51.0%)	(47.3%)
Non-Clinical Support Ser	399	212	3,991	4,570	(579)	4,789	5,814	(1,025)	(14.5%)	(21.4%)
Primary Care & Preventio	105	104	1,046	1,151	(105)	1,255	1,298	(43)	(10.0%)	(3.4%)
Social Care	1,109	1,092	11,092	12,107	(1,014)	13,311	14,797	(1,486)	(9.1%)	(11.2%)
Surgical Services	783	1,062	7,918	9,130	(1,211)	9,485	11,117	(1,633)	(15.3%)	(17.2%)
Tertiary Care	1,079	642	10,791	11,192	(401)	12,949	14,239	(1,290)	(3.7%)	(10.0%)
Women Children & Family	139	101	1,395	1,258	138	1,674	1,711	(37)	9.9%	(2.2%)
Grand Total	**8,012**	**10,112**	**82,977**	**98,949**	**(15,972)**	**97,195**	**114,819**	**(17,624)**	**(19.2%)**	**(18.1%)**

Year-to-date overspend £16.0m, made up of:

- £6.7m impact of baseline budget pressure (negative budget) apportioned evenly across the year
- Mental Health overspend £2.8m in relation to on- and off-Island placements and drug expenditure
- Surgical Services overspend £1.2m in relation to consumables mainly for Theatres and Day Surgery Unit
- Chief Nurse overspend £1.2m in relation to Accommodation Service
- Social Care overspend £1.0m in relation to domiciliary care packages
- Medical Director overspend £0.9m in relation to litigation costs and pharmacy consumables
- Medical Services overspend £0.7m in relation to consumables/medical supplies
- Non-Clinical Support Services overspend £0.6m in relation to estates compliance works and patient travel costs
- Estates overspend £0.6m in relation to maintenance works

Full year forecast overspend £17.6m, made up of:

- £9.2m impact of baseline budget pressure (negative budget)
- Mental Health overspend £3.2m in relation to off-Island placements and drug expenditure
- Surgical Services overspend £1.6million in relation to Theatres consumables and the charter flights contract
- Chief Nurse overspent £1.6m in relation to Accommodation Service
- Social Care overspend £1.5m in relation to care packages
- Tertiary Care overspend £1.3m on acute referrals to the UK, mainly due to overperformance on Southampton contract
- Non-Clinical Support Services overspend £1.0m in relation to Patient Travel and Estates Compliance
- Estates overspend £0.6m in relation to maintenance works

Income Position – Month 10

Subjective Category Detail	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Sale of Services	(1,818)	(1,878)	(17,758)	(16,772)	(986)	(22,265)	(21,039)	(1,226)	(5.6%)	(5.5%)
Patient Charges	(210)	(541)	(2,098)	(2,853)	755	(2,518)	(3,702)	1,184	36.0%	47.0%
Other Income	(105)	(381)	(1,050)	(1,344)	294	(1,261)	(1,704)	443	28.0%	35.2%
Sale of Goods	(17)	(48)	(167)	(123)	(43)	(200)	(101)	(99)	(26.0%)	(49.5%)
Other Fees	0	0	0	(42)	42	0	(70)	70	0.0%	0.0%
Fees and fines	(1)	(7)	(13)	(37)	24	(15)	(40)	25	195.1%	166.7%
Course Fees	4	(3)	43	(34)	77	51	(31)	82	(180.0%)	(160.0%)
Grand Total	**(2,146)**	**(2,857)**	**(21,043)**	**(21,205)**	**162**	**(26,207)**	**(26,686)**	**479**	**0.8%**	**1.8%**

Year-to-date £0.2m over-achieved, made up of:

- Surgical Services- underachieved £1.9m, mainly relating to under-achievement in relation to Private Patient income across Theatres and DSU)
- Chief Nurse- overachieved £0.8m in relation to Accommodation Service income
- Intermediate Care and Mental Health- overachieved £0.8m in relation to Long Term Care Benefit
- Director General's Officer- overachieved £0.5m relates to staff recharged to Our Hospital Project (costs of staff also accounted for in same cost centre)

Care Groups & Directorates	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	(208)	(542)	(2,085)	(2,873)	788	(2,502)	(3,692)	1,191	37.8%	47.6%
Director General's Offic	(10)	(78)	(99)	(556)	457	(118)	(76)	(42)	463.1%	(35.8%)
Estates & Hard Facilitie	(0)	0	(3)	(13)	10	(4)	(13)	9	288.5%	230.8%
Intermediate Care	(100)	(157)	(900)	(1,237)	337	(1,200)	(1,689)	489	37.4%	40.7%
Medical Director	(71)	(10)	(713)	(843)	130	(855)	(993)	138	18.3%	16.1%
Medical Services	(449)	(121)	(4,488)	(4,255)	(232)	(5,385)	(5,257)	(128)	(5.2%)	(2.4%)
Mental Health	(20)	(47)	(180)	(605)	425	(240)	(911)	671	236.0%	279.4%
Non-Clinical Support Ser	(83)	(216)	(828)	(971)	143	(994)	(1,239)	245	17.2%	24.6%
Primary Care & Preventio	(14)	(11)	(141)	(126)	(15)	(622)	(617)	(5)	(10.6%)	(0.7%)
Social Care	(311)	(394)	(2,816)	(2,644)	(172)	(3,738)	(4,137)	399	(6.1%)	10.7%
Surgical Services	(855)	(1,062)	(8,553)	(6,655)	(1,898)	(10,263)	(7,533)	(2,730)	(22.2%)	(26.6%)
Tertiary Care	(13)	(12)	(125)	(120)	(5)	(150)	(168)	18	(3.8%)	11.8%
Women Children & Family	(11)	(209)	(113)	(307)	193	(136)	(362)	226	170.6%	166.2%
Grand Total	**(2,146)**	**(2,857)**	**(21,043)**	**(21,205)**	**162**	**(26,207)**	**(26,686)**	**479**	**0.8%**	**1.8%**

Full-year £0.5m over-achieved, made up of:

- Surgical Services- underachieved £2.7m, of which majority relates to Private Patient Accommodation and Main Theatre Charges.
- Chief Nurse- overachieved £1.2m in relation to Accommodation Service income
- Intermediate Care, Mental Health and Social Care- overachieved £1.4m in relation to Long Term Care income and rebate to Alcohol & Drugs Service
- Non-Clinical Support Services- overachieved £0.2 million in relation to Laundry and Catering income

Health and Community Services

Health and Community Services Advisory Board Report

Report to:	Health and Community Services Advisory Board		
Date of meeting:	6th December 2023		
Title of paper:	Workforce Report – October data		
Report author (& title):	Steve Graham, Associate Director of People - HCS	**Accountable Executive:**	Chris Bown, Chief Officer

1. Purpose

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

2. Executive Summary

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

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

3. Finance / workforce implications

See main report.

4. Risk and issues

See main report.

5. Applicability to ministerial plan

See main report.

6. Main Report

See attached.

7. Recommendation

For noting.

Health and Community Services

Advisory Board

Workforce Report

(October 2023 data)

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Executive Summary

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

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

Metric	Dec 22	Mar 23	June 23	July 23	Aug 23	Sept-23	Oct-23
Funded Establishment – FTE	2631	2675	2709	2721	2801	2863	2902
Staff in post – FTE	2200	2239	2228	2221	2274	2405	2424
Vacant – FTE	411	436	481	501	527	458	478
Vacancy Rate	16%	16%	18%	18%	18%	16%	16%
Agency staff (headcount)	133	175	176	193	205	201	
Total Turnover Rate	7.5%	6.2%	6.5%	6.6%	7.3%	7.0%	7.0%
Voluntary turnover rate	5%	4%	4%	4.1%	4.4%	4.3%	4.2%
Leavers Headcount	26	15	13	12	14	16	11
Sickness Rate	6%	4.8%	5.6%	5.6%	5.6%	5.5%	5.5%
Training compliance Rate	TBA						
No objectives		0.5%	0.5%	No data	0.5%	0.5%	0.5
With Objectives		93%	80.6%		73%	70.8%	66.7%
With Manager		3%	7.6%		7.5%	5.7%	6.8%
Objectives approved		3%	10%		9.9%	21.5%	12%
Mid-Year Review Complete			0.3%		6.8%	10.6%	13.5%
Year-end review							0.5%

Work between the finance team and the HR Resourcelink team to reconcile the differences between systems has now completed and the new hierarchy has been loaded into the Connect system. This will provide us with a single source of truth for vacancies and recruitment pipeline data.

The vacancy numbers through 2023 have increased again in October due in the main to an increase in funding due to Government Plan and business case funded roles coming online from January 2023. This has increased funded establishment by 271 WTE since the beginning of 2023 and has had a

corresponding impact on the overall vacancy number which has increased as has the vacancy rate and the agency numbers.

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

The total turnover rate has remained constant at 7.0%, whilst the voluntary turnover rate (i.e. resignations) has also remained constant at just over 4%, this is equivalent to 171 staff resigning over the previous 12 months.

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

The October data for objective setting shows further movement in the approval of objectives and the mid-year and the start of end of year reviews. However, this is still low and will remain an area of focus for Executive team with an action plan for increasing uptake in place for 2024.

Workforce data

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

	Funded Establishment (WTE)		
	Oct-22	**Aug-23**	**Oct- 23**
Medical	229	250	278
Nursing	691	737	754
Healthcare Assistants	400	427	445
Civil Servants	917	1041	1075
Manual Workers	357	346	350
Total	2590	2801	2902

This table shows the increase in WTE staff in post across the staff groups with recruitment into the civil servant group our most successful. The group includes our Allied Health Professionals.

	Staff in Post (WTE)		
	Oct-22	**Aug-23**	**Oct-23**
Medical	188	204	237
Nursing	554	561	600
Healthcare Assistants	346	357	370
Civil Servants	759	841	891
Manual Workers	321	311	325
Total	**2168**	**2274**	**2423**

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

	Vacancy Rate		
	Oct-22	**Aug-23**	**Oct-23**
Medical	19%	18%	15%
Nursing	20%	23%	20%
Healthcare Assistants	13%	20%	17%
Civil Servants	17%	19%	17%
Manual Workers	9%	10%	7%
Total	**16%**	**18%**	**16%**

Recruitment Activity

It is recognised that the time to recruit is currently too long, leading to reputational risks and to a high use of agency and locum workers which is costly for the department. It has now been agreed that the Government of Jersey's Delivery Unit will work with HCS and the People team to address this issue. Additional resources have now been agreed to redesign the recruitment pathway and processes.

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

A mass (or cohort) recruitment campaign is in development for nurses, including the creation of a Microsite containing relevant information for an interested candidate.

A specific social media campaign has been designed for the recruitment of physiotherapists and work is underway to develop a similar campaign for Pharmacists and Pharmacy Technicians.

There are also plans to utilise specialist agencies for the recruitment of experienced colleagues such as nurses, Allied Health Professionals and doctors. This approach is starting to show results with 11 candidates offered roles with start dates throughout 2023. These candidates would have been unlikely to apply via the normal routes.

A redesign of the end-to-end process within HCS to ensure the “mass recruitment process” has potential and will introduce the concept of creating a bank of reserve second choice candidates.

The department has been involved in the creation of the Priority Worker policy to support accommodation for candidates, which will enhance our onboarding offer.

Recruitment Pipeline

Work continues to establish a process to produce data on the recruitment pipeline going forward, which will describe the number of roles in active recruitment, length of time to recruit and projected start dates to manage any locum/agency cover for the vacancy.

It is anticipated that a single source of all recruitment information will be available shortly which will provide the detailed information required to predict further when future recruits will be joining HCS.

Whilst data is not available for all staff groups, the table below shows the pipeline information we have for the recruitment into nursing roles.

Start date confirm (up to January 2024)	Candidate in clearance process	Contract issued	Awaiting contract to be issued	Roles at interview stage	Roles at shortlisting stage	Recently advertised without applicants	Currently at live advert
25	28	11	5	7	5	12	63

Retention

The total turnover rate for the 12 months to the end of October remains constant at 7.0%, which equates to 171 people leaving HCS. The voluntary turnover figure (which relates to resignations) for the 12 months to end of October 2023 is 4.2%, down from 5.2% this time last year and 5% in the 12 months to the end of December 2022.

This equates to 102 leavers spread across the year. In addition, there were 35 retirements over the previous 12 months; the remaining 35 “involuntary” leavers consisted of 27 leavers due to end of contract (including the junior doctors), three leavers who failed their probationary period and five dismissals.

Exit Interviews

The Government of Jersey runs an online exit interview system, which captures leavers’ views on several topics. The data submitted by leavers is collated centrally for all leavers across Government.

The next update of the data is expected in December 2023 and will be reported to Board in January 2024.

Induction

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

My Welcome

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

HCS Induction

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

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

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

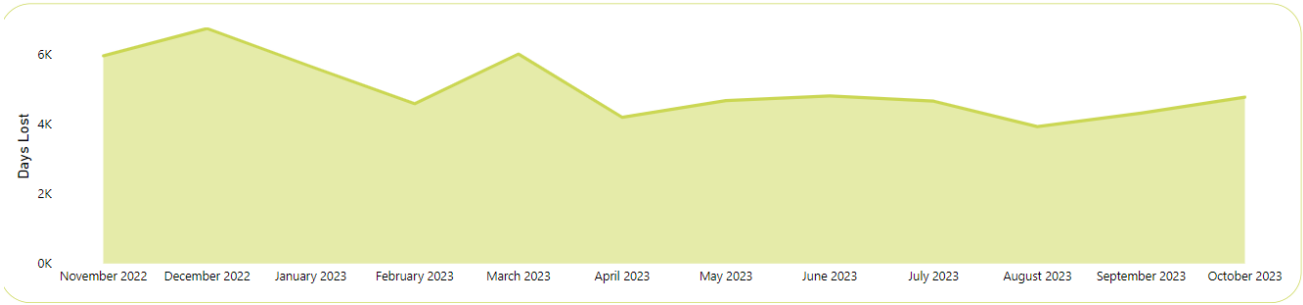
Learning and Development

Statutory and Mandatory Training - Placeholder

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

Health and Well Being

There had been a steady drop in the sickness absence rate from December 2022, however a slight increase has been seen over the last month as we approach winter. This is shown below in the graph showing days lost.



The main reasons for absence have remained constant with the predominant reason being recorded as Cough, Colds and Flu.

Employee Relations (ER)

HCS currently has 15 live formal ER cases across disciplinary, grievance, bullying and harassment, employment tribunal and capability processes. This is a decrease from 21 cases in March 2023.

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

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

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

Staff Appraisal and Development

The data on the usage of Connected performance is shown in the summary table at the beginning of this report.

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

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

An action plan will be developed for delivery of greater number of objectives during 2024.

Connect People

The Connect People programme has rolled out several modules during 2024 all of which will provide support to managers and employees as well as providing more accurate and timely workforce information.

Connect Performance

Connect performance was launched in early 2023 and is the online system for recording objectives, development needs and appraisals.

Connect Learning

This is the online portal for holding and recording learning programmes and will allow reporting of compliance with training requirements. HCS learning collateral is currently being reviewed to allow its movement onto Connect Learning

Employee Central

Employee Central was launched week commencing 20th November and is an online system for employees to make changes to their personal information and data. It is also the system by which managers can make changes to employment conditions of their colleagues, such as length of fixed term contract, change of hours or acting up, without the need for forms and central approval.

Talent Acquisition

Talent Acquisition will be rolled out at the end of December 2023 and is the online system for all recruitment activity. Managers will be able to initiate recruitment to a vacant budgeted role without the need for paperwork and central approval. In addition to simplifying the process for managers it will provide accurate recruitment information and pipeline data.

Health and Community Services

Health and Community Services Advisory Board Report

Report to:	Health and Community Services Advisory Board		
Date of meeting:	6th December 2023		
Title of paper:	Recruitment (Long Term Approach)		
Report author (& title):	Steve Graham, Associate Director of People, HCS	**Accountable Executive:**	Chris Bown, Chief Officer, HCS

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board?	To provide the Advisory Board with information on the plans for recruitment within Health and Community Services (HCS). To receive the report	Information	x
		Decision	
		Assurance	
		Update	

2. Executive Summary

The purpose of this briefing note is to provide the Advisory Board with details of the planned approach that will be taken to recruit into the HCS vacant roles.

Historically, HCS recruitment activity has relied almost exclusively on the gov.je website, some advertising on NHS jobs and occasional use of professional magazines. This has had limited success in attracting candidates in a highly competitive market.

Changes have been made to the way roles are positioned in the market to ensure maximum exposure in the marketplace to attract as wide a field of candidates as possible. Changes have also been introduced in the way candidates are handled during the process to ensure they have the best possible experience and quicker recruitment times. These changes include use of specialist recruitment agencies to identify interested candidates, development of microsite for “always on” nurse recruitment, greater use of professional journals and dedicated recruiter support for the recruiting manager and candidate through the process.

3. Finance / workforce implications

The changes will reduce the reliance of temporary workers and ensure a more stable and substantive workforce is in place to provide greater quality and continuity of care for patients. In addition, the reduction of temporary workers will reduce the financial impact of high-cost agency and locum workers.

4. Risk and issues

5. Applicability to ministerial plan

An important element of the ministerial plan is to have a stable workforce and less reliance of temporary

workers.

6. Main Report

HCS has been carrying a high number of vacancies for several years with a significant number of them covered by agency or locum workers at a high cost.

Recruitment process and candidate experience

Activity to support substantive recruitment within HCS has not been supportive to managers or candidates. Managers have struggled with the process required to get a post out to substantive recruitment and candidates have had an inconsistent experience whilst going through the process. In addition, roles have not always been advertised in the most competitive location.

Additional support has been put in place to support both managers and candidates through the process ensuring that shortlisting and interviews are in place as quickly as possible, and candidates are informed of their progress throughout the process. These changes, alongside other improvements in the central processing of applications and candidates and the newly introduced Key Worker accommodation policy are significant change in how candidates feel about their experience of joining HCS and will reduce the attrition rate of lost candidates due to slow process and poor experience.

Candidate attraction

The other element of the recruitment approach that has been changed and will continue going forward is how HCS gains interest and attraction from candidates in the first place.

One of the first approaches considered was the NHS approach of recruiting cohorts of international nurses. The first cohort targeted was for theatre nurses from India which identified an issue for HCS and Jersey. International nurses are not registered with the Nursing and Midwifery Council (NMC) and without that registration they cannot register with the Jersey Care Commission (JCC) and therefore cannot work in Jersey. It is possible to gain NMC registration as an overseas nurse by completing the Objective Structured Clinical Examination (OSCE), which is the path the NHS takes. However, we do not have the trainers required to train candidates in the exam and do not have access to an OSCE centre for candidates to sit the exam. Access to both proved time consuming and costly for HCS and was a poor experience for candidates. So this approach, whilst highly successful in the NHS, is something we cannot consider in HCS.

Therefore, several other approaches are in place to attract candidates,

- Wider use of NHS jobs. All clinical roles are now placed on NHS jobs which is the main portal that NHS workers use to find new roles.
- Following the decision not to pursue overseas nurses, specialist recruitment agencies have been commissioned to find NHS workers (already with NMC registration) who are looking for a new role. This has proven to be of success.
- Specialist recruitment agencies have been commissioned to identify potential overseas doctors and allied healthcare professionals (AHPs).
- More targeted use of professional media. A recent campaign in the Health Service Journal (HSJ) for psychiatrists attracted two appointable candidates to roles we had not been successful in filling for a long period. Similar campaigns will be used for other specialist roles.
- A specific campaign for mental health has been developed, which does not focus on any profession but on the whole mental health system.

- Increasing the number of nursing students we progress, and thereby attracting Jersey born talent. HCS has courses for general and mental health nurses which provides a regular flow of newly qualified nurses.
- Conversion of agency workers to substantive roles. As HCS shows more commitment and activity on filling to substantive roles, those colleagues who have been on long term agency contracts may well consider moving over to substantive contracts.
- A microsite has been developed for nurses across HCS which provides information on working in Jersey and working for HCS. Initially designed for nurses it will be developed to be suitable for all staff groups over time, The site is due to go live early in December 2023 and whilst always be on, pointing candidates to whatever HCS nursing roles are being advertised on gov.je website.

Other developments

More oversight and governance in place of vacancy and recruitment activity to ensure that roles are out to advertisement.

In 2024 explore the increased use of apprenticeship/traineeships to attract Jersey talent to join HCS and build their career with us.

Explore the introduction of new roles, such as Nursing Associates, to offer wider career development opportunities for staff.

Introduce a “Refer a Friend” scheme and trail recruitment bonuses to see if they offer incentives for people to join HCS.

The success of all the various activities will be monitored closely to ensure return on investment and to identify if further changes and /or development is required.

7. Recommendation

The Board is asked to note the contents of this report and the various ways the approach to recruitment within in developing and will continue to develop.

END OF REPORT

Health and Community Services

Health and Community Services Advisory Board Report

Report to:	Health and Community Services Advisory Board		
Date of meeting:	6th December 2023		
Title of paper:	Consultant and SAS Doctors Job Planning Cycle 2023/24 Monthly Update		
Report author (& title):	Patrick Armstrong, Group Medical Director	**Accountable Executive:**	Patrick Armstrong Group Medical Director

1. Purpose

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

2. Executive Summary

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

3. Finance / workforce implications

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

4. Risk and issues

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

5. Applicability to ministerial plan

Priority 1 of the Minister for Health & Social Services Delivery Plan is "Advancing the quality of Government of Jersey health and care services, ensuring they are well governed, safe and person centred."

6. Main Report *

Since the last report, a decision was taken by the Job Planning Consistency Panel to engage support in achieving completion of the job planning cycle. Two Allocate Job Planning System experts have been engaged to support the process, firstly, a workforce lead for the financial recovery programme (FRP) and secondly, a medical staffing expert. These experts have reviewed the set up in Allocate and have noted that there are inconsistencies with the way job plans are being recorded. Each department has been reviewed and data analysed expressed in each job plan which will be shared with each Clinical Lead. Some job plans have inadvertently been overridden; therefore, what may have been agreed in previous years cannot be seen. To safeguard existing data, ensure where job plans have been signed off and we have accurate and reflective job plans which can then be aligned to pay, we have decided to lock down job plans and to republish them with a start date of 1 January 2023. All job plans are now back in discussion.

Several amendments to the system are being implemented to enable the organisation to maximise the functionality of the Allocate Job Plan module.

Progress made since 23 October

23rd October 2023	
Signed Off or in Date	55% (83)
Awaiting 2nd Sign Off	3% (4)
Awaiting 1st Sign off (By Doctor or Manager)	12% (18)
In Discussion	31% (47)

As of 24 November 2023, all job plans have been locked down with an end date of 31 December 2022. All job plans have been reopened in discussion with a start date of 1 January 2023. This does not impact on medical pay. All job plans that had a second sign off during the 2023 cycle will be paid from the date of second sign off.

The sequence for the roll out for completing the medical job planning round for 2023 is as follows.

All job plans locked down by 24 November 2023. Work will be undertaken with Allocate to update the settings in the system to reflect more accurately the language and settings required by Jersey.

Doctors will be provided with specific support to assist them with entering their job plan onto the system using consistent criteria by speciality, in the order listed below:

- Anaesthetics and Critical Care
- General Surgery, Trauma and Orthopaedics.
- Medicine to cover all GIM and Acute doctors.

- Paediatrics, CAMHS and O&G.

- Radiology, Oncology, Emergency Department.

HR analytics are running a report regarding pay elements which will support the team in identifying which programmed activities (PA) are currently being paid and what responsibility/management allowances are also paid. This will be used to inform job planning meetings. The two experts will be available to assist consultants and SAS doctors in inputting their job plan into Allocate, in readiness for the job planning meeting with clinical lead/Chief of Staff.

The job plans should all be completed for the current year by March 2024.

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

7. Recommendation

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

END OF REPORT

Health and Community Services

Health and Community Services Advisory Board Report

Report to:	Health and Community Services Advisory Board		
Date of meeting:	Wednesday 6th December 2023		
Title of paper:	Winter planning 2023/24		
Report Author	Claire Thompson Chief Operating Officer- Acute Services. Andy Weir Director of Mental Health and Adult Social Care	**Accountable Executive:**	Claire Thompson and Andy Weir

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board? *(brief statement & tick as appropriate)* *Any pre-reading*	The report seeks to provide assurance to HCS Advisory Board of the process taken regarding the development of the winter plan for 2023/24 with a summary of associated actions to mitigate potential operational impact.	Information	☑
		Decision	
		Assurance	☑
		Update	

2. Executive Summary

Key actions have been taken that will support Health and Community Services (HCS) to respond to seasonal variation in demand for services in acute physical care. A review of previous years data has occurred to inform the planning cycle based on winter activity trends from 2021. The approach to the winter builds on successful actions that supported our previous year's plan and included a series of meetings to develop our approach held with key clinical and operational staff in the relevant care groups. A review of the NHS Winter plan interventions occurred to provide useful reference for consideration. This has demonstrated similar focus areas on Urgent Emergency Care (UEC) including the Emergency Department (ED), same day emergency care (SDEC) and ambulance handover times, respiratory services and reducing variation in pathways and operational flow. The latter elements are contained in our clinical productivity financial recovery programme (FRP) work. Some of the high impact interventions advocated are currently limited due to resourcing such as frailty capacity and virtual wards but will provide an ongoing framework for improvement and subsequent planning 24/25.

Of note, HCS was able to continue to reduce its overall waiting list at Q4 2022/Q1 2023 as was noted by the Health Scrutiny Panel earlier this year. Also, there was no requirement last winter, to surge critical care capacity into our theatre environment (with consequence to planned elective activity) which had been a feature of winter 2021/22. In addition, winter 2023/24 is the first winter period post Covid, that HCS will have additional acute bed capacity (28) to open as needed, through the in-year completion of the refurbishment of Plemont ward.

The efficacy of the plan will be monitored through standard bed meeting/operational flow processes and quality performance metrics regarding elective activity, standard wait times ED, patient feedback as examples.

3. Finance / workforce implications

The need to provide additional acute capacity to the standard bed state is generally responded to by additional workforce gained by a variety of sources such as substantive staff working additional voluntary hours, standard bank and agency approach. Although steps are taken to mitigate the need for an increase in admissions, surge capacity is a necessary feature of winter response and additional resource is required to cover the associated pay and non-pay activity. Recent decisions to substantiate additional but long-standing open medical capacity will reduce the premiums associated with meeting winter surge and reduce costs associated with maintaining this when compared to previous years.

Recruitment of substantive and temporary staff is in progress to support the additional capacity. Incentives for permanent staff and the uptake of hours to support winter surge are under development including in-month pay, weekly pay and higher rates of pay for shifts booked more in advance which in turn reduces dependency on agency.

The approach to staff screening considerations and vaccination programme is described below in the infection prevention and control (IPAC) section.

4. Risk and issues

Work to evolve the level of data regarding patient activity will develop HCS's ability to robustly prepare and evaluate the success of winter planning cycle and interventions. Poor planning would give rise to increased risk of a lack of availability of skilled staff and drive higher associated workforce costs or reduce the ability to surge additional capacity safely. Staffing has been reviewed across both substantive and temporary cohorts to ensure that rota planning is robust and the need for bank or agency is minimised but that adequate staffing levels are maintained and the ratio of temporary to permanent staff is observed and adequate. This has been led by the Chief Nurse.

Progress made on elements of the Royal College of Physicians (RCP) review of Acute Medicine that include the substantiation of the correct required level of medical capacity will reduce both financial and quality risks associated with this winter. This will support delivery of our objectives that relate to both waiting list and financial recovery plans as well as the quality of care and experience of our patients.

5. Main Report

Data analysis from previous winter periods, identified that length of stay in ED increases during winter months. This could be due to challenged flow as well as acuity of presentation. An increased conversion rate for admissions is also noted for winter months for ED attendances alongside a marginal increase in the data of the number of delayed transfers of care (DTOC) patients. Staff report more difficulty with securing ongoing placement for medically fit patients with external providers citing leave of their staff over the holiday period as a contributory factor and improvement as we progress into January and spring is noted. Through the winter planning meetings, care groups have developed winter planning schemes. These include:

- Additional physical capacity of 28 beds for medical admissions which will reduce the likelihood of the need to place medical patients into surgical capacity. Additional staffing has been costed as part of the RCP response and will be mitigated by 2024 FRP clinical productivity workstream delivery.
- Ability to care for respiratory patients with higher dependency need on the inpatient ward through training and service development. This reduces demand on the intensive care unit (ITU) and avoidance of the need to surge Critical Care capacity. This winter our respiratory clinical nurse specialists will in-reach into the acute ward to aid discharge planning and support care delivery.
- Additional consultant led reviews of deteriorating or discharge patients at the weekend to support patient flow and patient care pathways. Not all wards currently achieve Monday-Friday due to consultant constraints however provision of this service will enable increased discharges at weekends and has had positive impact to date.

- An ambulance handover area to increase capacity and enable rapid handover of inbound ambulances. The area will mitigate offload delays.
- The development of SDEC.
- Paediatric ability to surge from 10 to 13 bed capacity as required.
- Operational flow improvements Red2Green and the SAFER care bundles are examples from the NHS which are being implemented to improve patient flow. This improvement activity sits as part of the clinical productivity FRP workstream.
- Intermediate Care weekly DTOC meetings chaired by the Director of Mental Health and Adult Social Care are in place. Potential to develop admission avoidance being explored across sites. Increased system partner attendance will also be encouraged enabling a system-wide overview. An interim brokerage for care packages via Customer and Local Services (CLS) will reduce delay in allocation of care packages.
- Discharge to Assess pilot model being developed for consideration in Q1 2024.
- Mental Health services continue to operationally review the bed state daily and utilise the Home Treatment Team to prevent admission or facilitate early discharge with intensive community support and are exploring the potential use of temporary accommodation to reduce delayed discharges as a result of housing need.

Infection Prevention and Control

The experience of Winter 2022/23 included the unexpected arrival of additional organisms such as Streptococcus A and IGAS that required isolation, in addition to influenza and covid and further highlighted challenges with the availability of side/isolation rooms in our estate. However, this was mitigated by the purchasing of environmental cubicles that were deployed into acute wards to support the infection control management. Winter vaccination programme has commenced within HCS. An update on the programme is outlined in this month's Chief Nurse IPAC report.

A review of current policy to Covid staff screening has been considered by the HCS Senior Leadership Team (SLT) that compared the approach in the UK/recent guidance. The isolated position of HCS was noted considering a need for enhanced resilience and this was supported. This policy would support the re-introduction of protective measures such as personal protective equipment (PPE)] and staff screening depending on risk factors and the prevalence of disease and will be overseen by the Chief Nurse and Medical Director.

6. Applicability to ministerial plan

Winter planning is an annual feature of healthcare management to mitigate any associated impacts of an increase in emergency demand due to seasonal impact on disease. This allows healthcare systems to take steps to reduce demand or increase capacity, therefore maintaining both access to and ensuring high quality safe care. In addition, winter planning focuses on the availability of workforce to meet increase in demand. High quality care, with good access to essential services and improving the experience of our workforce are all central features of the current ministerial plan for HCS.

7. Recommendation

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

In addition, the board is asked to note that Beauport ward has also been refurbished in 2023 providing for higher levels of compliance to health technical memoranda (HTM) standards within the current acute bed state and an improved experience for patients and staff. This has been delivered through the hard work and commitment of not only our estates staff but the clinical and operational leaders within medicine and surgical care groups to plan the significant activity associated with moving acute wards from different parts of the estate in addition to the crucial support from non-clinical staff such as cleaners, porters and infection control teams. This is in addition to normal activity and is a feature of working in aged infrastructure.

END OF REPORT

Health and Community Services

Meeting Report

Report to: *(delete as appropriate)*	Health and Community Services Advisory Board		
Date of meeting:	6th December 2023		
Title of paper:	Serious Incidents		
Report author (& title):	Andrea Bowring Head of Patient Safety	**Accountable Executive:**	Patrick Armstrong Group Medical Director

1. Purpose

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

2. Executive Summary

Work continues towards providing robust assurance that Health and Community Services (HCS) has learnt and implemented lessons from incidents to reduce the risk of recurrence. There is an acknowledgement that there is much work to be done. This paper provides the Board with information on both process performance and actions taken to address issues.

The current position is:

- HCS have 42 Serious Incidents (SI's) currently open.
- 29 SI's are overdue.
- Since the last Board report, seven SI investigations were presented to Serious Incident Review Panel (SIRP) and six reports were closed with their recommendations accepted. One report has been asked to return back to SIRP in December 2023.
- There are a further seven reports that are planned to be presented to SIRP before the end of the year.
- There are three SI investigations that have not commenced. The longest open without an investigator is one month and two are open two weeks.
- The Chiefs of Service have been supporting the Quality and Safety (Q&S) team with the allocation of SI investigators. The three unallocated SI's have been escalated to the Chiefs of Service who are looking to allocate the investigators within their Care Group.
- To ensure the organization is learning from these incidents within an accepted timeframe the Chiefs of Service along with the Chief Nurse and Medical Director are supporting staff by offering them protected time to complete the reviews in a timely manner.
- Immediate patient safety concerns are addressed, and patients/relatives and staff receive the appropriate support at the safety huddle which is called for every potential SI to ensure that urgent actions can be implemented.

- The Q&S team are also overseeing a further investigation that does not sit under the remit of HCS, for example the Ambulance Service and / or Child and Adolescent Mental Health Services (CAMHS).
- An interim Serious Incident Reviewer commenced work with the Q&S team on Monday 13 November 2023. The reviewer has been allocated current key priority pieces of work to support investigators that have had work ongoing since 2022. The reviewer has completed one SI report in draft and aims to have a further two reports ready to be shared at SIRP before the end of the year. They have been allocated incidents that were not progressing in the first instance to prioritise and also some new incidents. It is anticipated that the interim will support staff that have recently been trained in root cause analysis to support succession planning within HCS.
- The Q&S team are looking to see if there is capacity to repurpose a role within the team to support a second position.

3. Finance / workforce implications

- The HCS Senior Leadership Team (SLT) agreed to offer investigators protected time to carry out investigations. If investigators require time from clinical duties, this request would be made to the Chief of Staff or Lead Nurse for that area. This has not been utilized by staff in the process of completing their SI report as many investigators have booked clinical commitments. Theatre schedules, clinics and off duties are scheduled 6-10 weeks in advance and therefore being released is an additional challenge of having someone to cover. New investigators are being offered this as soon as they are asked to complete an SI so that they can book some time off and arrange backfill. Job planning for consultants is being completed with time built in for governance activity such as SI investigation. This should reduce some of the pressures on availability of consultant staff.
- Care Group Governance Meetings chaired by the Medical Director and Lead Nurse commenced in October 2023. Open SI's and open and outstanding SI recommendations are part of this meeting.
- A UK external investigation company has been commissioned to carry out a thematic review of incidents of Massive Obstetric Hemorrhage (MOH) that have occurred within HCS (20 cases).
- An interim Serious Incident Reviewer has been appointed to help carry out investigations. They will support the investigators finalize overdue reports and help investigate the cases where no investigators have been sourced.
- The Q&S team are looking if there is capacity to repurpose a role within the team to support a second position.

4. Risk and issues

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

5. Applicability to Ministerial Plan

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

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

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

6. Main Report

Throughout the year, the Quality and Safety team have continued to work in collaboration with the Care Groups to increase the focus on patient safety and to share learning from patient safety incidents. **42** SI's are currently open and three have not been allocated investigators. 29 of these SI's are now overdue. With the appointment of the interim SI investigator, the aim is to reduce this number significantly over the next 3 months.

Care Groups	**Number of SI's open**	**Time since SI's have been declared**	**Further information**
Medical	17	2 x 19 months 1 x 17 months 1 x 12 months 1 x 8 months 1 x 6 months 1 x 5 months 1 x 4 months 3 x 3 months 2 x 2 months 2 x 1 month 1 x 2 weeks 1 x 1 week	1 open SI's which is a slight increase since last month. The interim SI investigator is focusing on supporting the Q&S team with finalising the two investigations that have been open 19 months. **Without investigators: There are two SI's that have not been allocated investigators.** • 1 open 1 month • 1 open 1 week
Mental Health	8	2 x 14 months 1 x 11 months 3 x 7 months 1 x 6 months 1 x 3 months	Eight open SI's which is consistent with the previous month. • Two SI's were closed in the previous month and two were opened. • One report has been received which has been shared with the Care Group and will be presented to SI panel December 2023 • All SI's have allocated investigators.
Women's and Children's	6	2 x 6 months 1 x 5 months 1 x 3 months 1 x 2 months 1 x 1 month	Six open SI's. All have allocated investigators. • Four reports were being presented to panel November 2023, of which three were accepted and finalized. •
Surgical	7	1 x 15 months 2 x 12 months 1 x 5 months 2 x 2 months 1 x 4 days	Seven open SI's. • The draft report for the SI open 15 months which is currently going through the quality assurance process. • There is one SI that has not been allocated which is open 1 month.
Intermediate Care	1	1 x 3 month	This is allocated and currently being investigated

Joint Medical and Surgical	2	1 x 5 months 1 x 3 months	Both draft reports have been received and shared with Care Groups. one report is due to be shared at SIRP 1st December and the other on 15th December 2023.
Joint Mental Health and Ambulance	1	1 x 10 months	This report is returning to panel December 8th, 2023.

Themes of SI's and Learning

Themes of the SI's that have been declared since September 2023.

- Women and Children Care Group: An independent UK company has been commissioned to thematically review 20 cases involving Massive Obstetric Hemorrhages which have occurred within the organization within the last year. The Care Group are ensuring safety huddles are occurring following an MOH. Work on the recognition of post-partum hemorrhage (PPH) within the department has happened and all MOH's are now documented on a proforma. This is being overseen by the Medical Director.
- Medicine: Concerns were raised regarding the use of psychotropic medication and its prescribing within the hospital. A working group has been established to review the prescribing of these medications, including the training and support offered to the wider staff teams. This is being overseen by the Director of Mental Health and Adult Social Care.
- On the back of a number of Serious Incidents in 2022 the Recognize, Escalate and Rescue (RER) Quality Improvement project commenced across HCS, this has continued throughout 2023 consolidating learning from Serious Incidents and incidents and working with the multi-disciplinary teams looking at numerous aspects of care including handovers, ward rounds safety huddles, education and training. This is being overseen by the Medical Director.
- Hydration and Nutrition was identified as an area of concern across the inpatient wards. An immediate action was put in place to carry out an audit. The results of this were shared with panel members. Further work is being done such as introducing regular snacks and protected mealtimes. The audit is being developed further with a UK company to ensure HCS captures the specifics of the quality of the delivery of hydration and nutrition on the wards. This is being overseen by the Chief Nurse.

Shared Learning:

- There are currently 20 open Patient Safety Investigations that have been categorized as causing moderate harm or above. All these have been allocated investigators and are either being reviewed or awaiting final approval. The patient safety team continue to meet with the Lead Nurses and Heads of Service monthly to discuss all Datix that are graded as moderate and above and any outstanding and overdue Datix. Immediate actions are put into place and some Datix closed at these meetings.
- The Quality and Safety Team review all incidents reported across HCS, this additional oversight provides assurance that issues that are reported are being appropriately escalated.
- Across HCS incident reporting has been increasing each quarter, this is a positive sign of a safety culture and to be encouraged.
- A significant amount of work has been carried out within the Woman's and Children Group to improve the recognition and management of MOH's. The organization has seen learning regarding the detection and management of MOH's. During the months of October and November, nine incidents of MOH were notified to panel. Seven of these incidents were not declared as SI's as the detection, care and treatment of the MOH was not of any concern.
- Themes of SI's are shared and the importance of reporting safety events highlighted in the

training to the junior doctors delivered by members of the Q&S team.
- The Surgical Care Group is now ensuring that all incidents where a patient has unexpectedly returned to theatre is now reported on Datix.

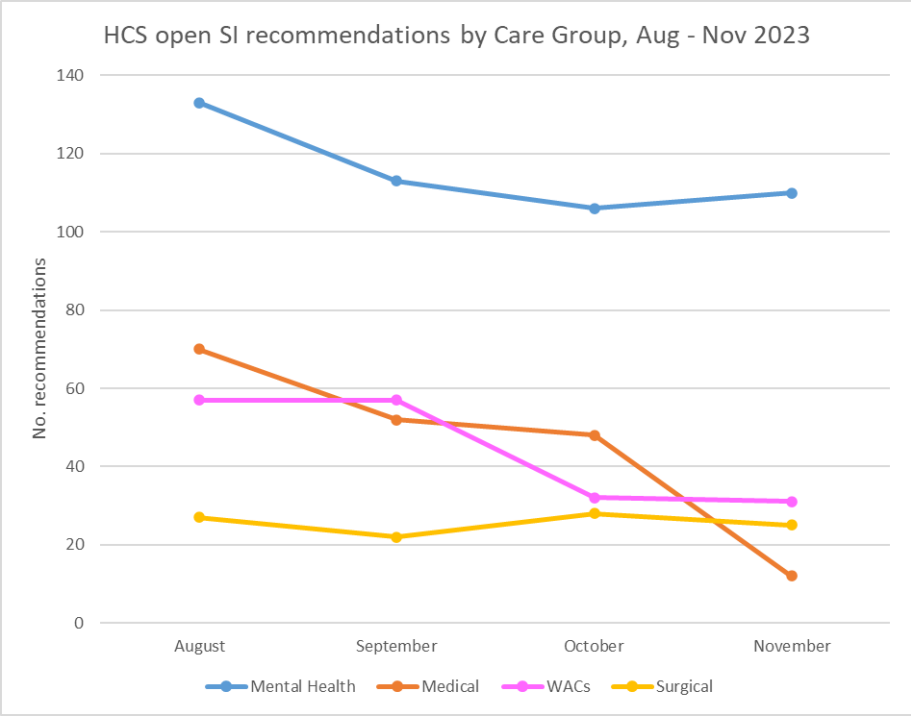
Care Group Governance Meetings/Lead Nurse Governance Meetings

- Care Group Governance Meetings occur monthly. These are chaired by the Executives and strengthens the process of accountability and oversight at executive level.
- In November, the first Lead Nurse Governance meeting occurred. The data was pulled by the Q&S team, which will drill down further than the Care Group Governance Meetings to look at ward data. Feedback from this meeting was positive and all information has been shared with the ward managers.

Serious Incident Recommendations

At the request of the Patient Safety team, Quality Improvement have been supporting them with the review of all open serious incident recommendations. All closed recommendations have been reviewed to ensure that evidence of implementation and embedding into practice has been provided. Meetings are continuing with all Care Groups to review their recommendations.

The Medical Care Group have now closed the majority of their open SI recommendations, with only 16 remaining open. The Care Group has provided robust evidence of work to ensure changes have been made and lessons learnt to ensure the recommendations can be closed.



END OF REPORT

Health and Community Services

Health and Community Services Advisory Board Report

Report to: *(delete as appropriate)*	Health and Community Services Advisory Board		
Date of meeting:	6th December 2023		
Title of paper:	Royal College of Physician's report Acute Medicine Improvement Plan progress		
Report author (& title):	Adrian Noon, Chief of Service Medicine, Aisling Adams, General Manager Medicine and Phil Toal, Project Manager	**Accountable Executive:**	Claire Thompson, Chief Operating Officer – Acute Services

1. Purpose

What is the purpose of this report? What is being asked of Board?	To provide an update on the progress of the Royal College of Physicians (RCP) Acute Medicine report and the actions taken against the recommendations.	Information	
		Decision	
		Assurance	
		Update	X

2. Executive Summary

Medical Services at Health and Community Services (HCS) have been subject to external reviews with a series of recommendations. The recommendations from these external reports have been collated into a comprehensive action plan to track progress and deliver improvements to care.

The Board was informed of the medicine improvement plan on the 1st of November 2023 and progress made to date. A further visit from Dr Rob Haigh occurred on the 30th and 31st October 2023 and although awaiting report of findings, verbal feedback has been received and is being actioned. The medicine improvement programme group takes place on fortnightly basis chaired by the Chief Operating Officer - Acute services.

3. Finance / workforce implications

There are challenges surrounding our current medical model. Currently, locum consultants provide ward-based care, and our substantive consultants are specialty based. The exception is acute medicine as we have substantively recruited to the vacancies.

The medical care group have developed the future vision of the medical model to ensure resilience and evidence based high quality care in our base wards. Without the required workforce model, embedding sustained change to care delivery will be challenged. This is being considered at the HCS Senior Leadership Team (SLT) meeting 29th November 2023.

4. Risk and issues

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

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

5. Applicability to ministerial plan

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

6. Main Report

Additional Management oversight has been put into place as previously stated. The care group senior leadership team meet weekly to go through the plan, update and progress actions. Additional quality improvement capacity has been commissioned and started 20th November.

From this report all recommendations are in progress with 26 recommendations showing evidence to date. Eight of these recommendations have made significant progress and four are marked as complete. Most noteworthy progress can be seen against immediate actions, 0-3 months and 0-6 months. A breakdown of these can be seen in Appendix 1.

	Total Number	In Progress	Complete
Critical	1	0	1
High	9	7	2
Medium	8	8	0
Low	8	7	1

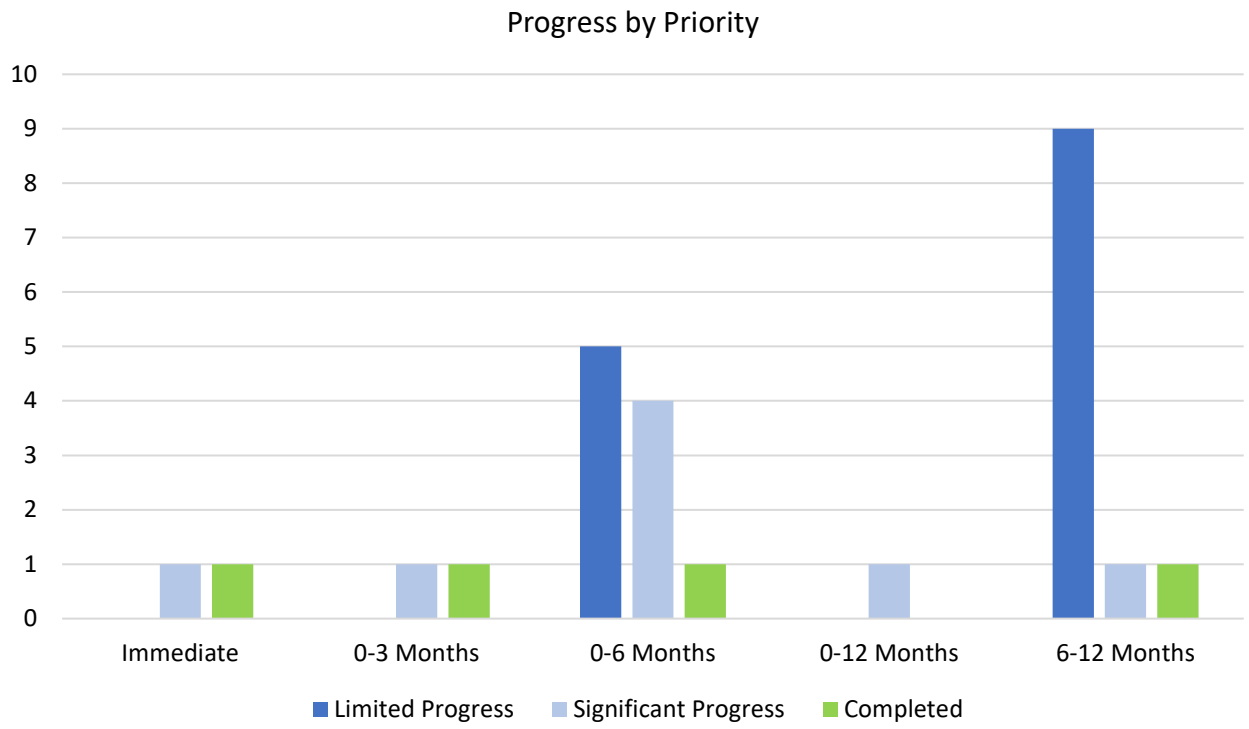
Evidence for each recommendation is tracked through Microsoft Lists and can be accessed through this link MIP Recommendations. Actions are tracked on a weekly basis, 55% of these weekly actions are complete, 43% progress and 2% not started. These can be view through this link MIP Action Tracker. The progress to date is detailed in the appendix 1.

7. Recommendation

The Board are asked to note the above. Regular updates will be provided by virtue of individual report updates and/or update overview of the work from HCS Change Programme Board into which the medicines improvement group (MIG) reports.

Appendix 1 - Recommendations

The breakdown of progress against priority for the 2022 Invited Review can be seen below.



Completed

Recommendation	Progress	Status
The executive team should support the department to make electronic prescribing systems (EPMA) available across the organisation, this is to ensure that all staff can access the system and access appropriate medication for their patients for whichever unit they are staffing at the time.	EPMA roll out plan agreed and shared with organisation 21/06/2023 with go live scheduled Tuesday 11th July 2023. Training for existing Emergency Department (ED) staff scheduled for training. Email from EMPA detailing the successful roll out of package. EMPA now operational with training in place for new starters.	Complete
A potential patient safety issue was highlighted with the mixed economy of inpatient drug prescribing, paper in the emergency department (ED) and intensive therapy unit, electronic prescribing and medicines administration (EPMA) on AAU and base wards such that nurses cross covering staffing gaps in other areas e.g. ITU nurses were not able to utilise the EPMA system and thus not administer medications in a timely manner. There is an immediate need to ensure that ED and ITU are updated to the EPMA system and/ or ensure that the relevant ED/ ITU nurses can access the EMPA system so that medications can be administered to patients on the AAU without delay.	EPMA roll out plan agreed and shared with organisation 21/06/2023 with go live scheduled Tuesday 11th July 2023. Training for existing ED staff scheduled for training. Email from EMPA detailing the successful roll out of package. EMPA now operational with training in place for new starters.	Complete
The clinical fellow rotas and induction required updating.	Clinical fellow rotas have been updated and available on Health Rota. Induction programmes are in	Complete

The healthcare organisation should ensure that the clinical fellow grades have: an induction commensurate to the proposed length of time that they are expected to stay which should include a named clinical/educational supervisor. a rota populated and circulated at least 6 weeks in advance.	place. There is evidence of ongoing training programmes from areas such as AAU. Sessions are evaluated. Clinical Fellows also have supervisors, but this has required updating due to changes in staffing.	
At the time of this review, the weekend cover for patients relied mostly on junior staff. The healthcare organisation should support the review of out of hours working regarding consultant delivered care on the AAU at weekends with the aim that all patients across the AAU and base wards should be in receipt of a consultant review daily seven days a week	The Medical Care Group has reviewed the weekend cover and completed a workforce plan. The weekly rota spreadsheet shows a consultant allocation on wards and AAU. Snapshots of this can be seen in evidence. Rota will also be moving to Health Rota so live updates can be seen.	Completed

Significant Progress

Recommendation	Progress	Status
This report should be considered by the executive team or relevant subcommittee and oversight of an action plan should be provided to a Non-Executive Board member to ensure these recommendations are completed.	Initial meeting to discuss the RCP report took place on 26/05/2023, a report was produced for the ELT for 05/07/2023. This report also contained a link to a draft action plan which was also approved. The draft action plan was also shared with consultants and senior nurses on 08/06/2023. Staff were invited to a session to explore the RCP and action place in the Halliwell on 06/07/2023 with an opportunity for staff to input via a Microsoft form. Oversight is provided through Charge Board and fortnightly executive lead meetings. **Outstanding – No non-executive board member allocated to monitor recommendations.**	In progress
The Medical Care Group should review the findings from the clinical record review (CRR) and ensure that any key learning points are fed back to the AAU teams at the governance meeting to embed learning within the workforce.	The findings of the RCP report have been shared with all members of staff who contributed to the report. The action plan has also been shared with colleagues to they are aware of the response to the findings. A session to explore examples of good practice will take place on 19th December during the Medicine Inset, led by Chief of Service Medicine and using the documents submitted to the RCP. **Outstanding - Session to take place on 19th December.**	In progress
To ensure consistency of clerking patients, the AAU clinical lead should, in collaboration with junior staff, develop a formalised, consistent and robust approach to medical clerking. The department should consider developing a standardised medical clerking proforma. The medical clerking proforma	Proforma for surgical and medical wards developed as part of the RER process. A paper version has been created in advance of going live on Maxims. A proposed ward round structure has also been developed from RER. Lead nurse has developed a	In progress

should be ratified at the appropriate clinical governance meeting.	nurse template to support entry onto to Maxims and approached Maxims team about the created this on Maxims. Chief Operating Officer – Acute Services and Digital Nurse are working on a timeline for all proformas on Maxims. **Outstanding - Proformas to be attached to Maxims.**	
The healthcare organisation should ensure that all consultants have an up-to-date job plan which details their clinical commitments, in addition to other activities. The job plan should specify the standards expected for ward care.	Consultant job plans are now on Allocate with 87% completed and signed off 07-11-2023. Examples of the completed job plans can be seen alongside. **Outstanding - 13% remaining**	In progress
The review team acknowledged the new appointments made by the executive team to support governance arrangements within the service. However, there should be continued work on the quality and safety structures. The healthcare organisation should ensure that: teams are educated on the processes in place regarding governance. there is timely implementation of QI projects, and guideline and SOP updates.	Quality and Safety have provided a central structure, and the Medical Care Group has advertised for a governance lead with interviews conducted week beginning 20th November. A sessions explore governance processes, QI projects, guidelines and SOP updates is in place for 19th Dec Inset Day. **Outstanding - Gov Lead appointment and 19th Dec Inset covering above points.**	In progress

Appendix 2 – Related risks on risk register

Title	Department	Risk Concern / Hazard	Risk level	Progress
Lack of Substantive staffing causing continuity of care and quality issues	General Medical Wards	Virtually all our ward-based care is provided by locum consultants who although they are providing an excellent service are not invested in the long-term future of the care group and can leave at short notice causing disruption to rotas and patient care. This has been well documented across internal and external reviews and the need to recruit substantively to allow for consultant care to be resilient.	High	No change
EPMA prescribing in the Emergency Department	Emergency Medicine	EPMA rollout to the Emergency Department is delayed until at least August, but more likely October. EPMA is currently operational in all other areas of the hospital. Medications for patients who are being admitted are prescribed on the EPMA. However, these are missed if a patient stays in the ED for a prolonged period and there is no prescription for these on the paper drug chart used in the ED. Several clinical incidents including SIs have implicated dual drug prescribing (paper charts and EPMA) as a contributing factor.	Very low	Closed on 17/11/2023
Issues impacting access to patient data in ED due to various technical issues	Emergency Medicine	There are numerous issues impacting ED: • Maxims printing, freezing the Maxims screen and impacting multiple users. • EPMA mapping errors (and lost profile data), preventing direct access and contextual login to EPMA from Maxims. • Desktop profiles (size and space) stopping machines from working. O365 has exacerbated the situation. • Desktop logon times (3 minutes, this has reduced since new desktops). • Incorrect support advice • Proxy issues, this stops Maxims and other external site access. • New COWS extremely slow to login. Also not yet supported by the technical teams. • No wall mounted bed management view, very important and this was lost with Trak. • One corrupt machine now replaced. • Maxim's user adjustment issues, to be expected (e.g. bed plan not visual, no patient icons as Trak had) • New process with ePrescribing – adjustment to working practice.	Moderate	No change
Potential IT/ WiFi failure or lack of coverage could result in delayed treatment / medications	General Medical Wards	Failure of IT/ WiFi resulting in inability/ delay in accessing EPMA to administer medications to patients	Moderate	No change
Lack of MDT coordination across cancer specialities	Oncology	Lack of MDT coordination across cancer specialities	Moderate	No change

Health and Community Services

Health and Community Services Advisory Board Report

Report to:	Health and Community Services Advisory Board		
Date of meeting:	6th December 2023		
Title of paper:	Maternity Improvement Plan		
Report author (& title):	Livi Methven Higgins, Senior Change Manager / WACs SLT Approved	**Accountable Executive:**	Patrick Armstrong, Medical Director Jessie Marshall, Chief Nurse

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board?	To provide information and update on the Maternity Improvement Plan. The Board are asked to note the content of the report and acknowledge the ongoing progress of completion and recognise the challenges which remain regarding ongoing cultural issues.	Information	X
		Decision	
		Assurance	X
		Update	X

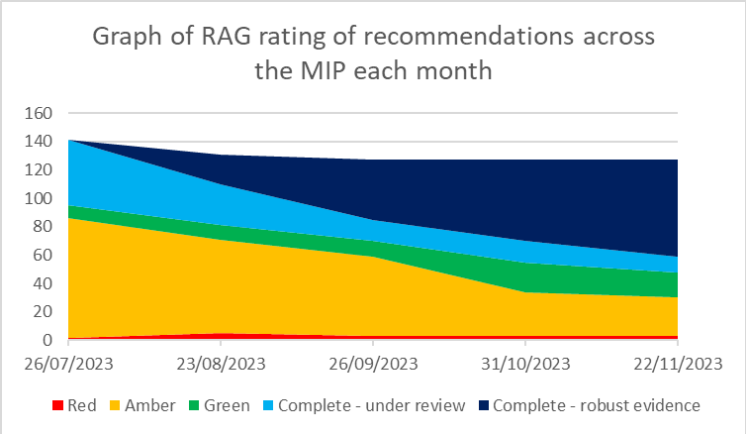
2. Executive Summary

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

During 2023, Maternity Services have been dedicated in ensuring that the MIP is successful, working alongside project management support, they have ensured business-as-usual processes are in place and scrutinised robust evidence. Maternity Services are cognisant that the pace needs to remain for 2024 where the focus will be on improving culture, multidisciplinary training and competencies.

During November further progress has been made:

- A further 13 recommendations have been approved by Women and Children's Senior Leadership Team as complete. Topics from these recommendations cover:
    - Jersey Neonatal Unit liaison with tertiary units
    - Risk assessments for falls, waterlow, nutritional assessment, moving and handling.
    - Consultant ward rounds
    - Clinical governance resource
    - CTG (Cardiotocography) guidelines, training and audit
    - Bereavement support for families



- Further recommendations have been identified as green as these relate to:
    - PVAD (Peripheral Vascular Access Devices) care bundle
    - Electronic monitoring equipment calibration
    - Datix reports investigated within 30 days.
    - Midwifery workforce review
- The previously red recommendation 137, "Care Group Performance Reviews standardised template and Maternity Care Group Performance Reviews to include a maternity risk report" has been made amber following approval of metrics and new governance meetings to support this. Recommendation to become green following 3 months of completed reporting.
- Submission made to the HCS Advisory Board 01 November 2023 with updates provided in the Maternity Dashboard
- The Perinatal Mental Health Midwife has:
    - in collaboration with the Maternity Voices Partnership and multi-agency mental health colleagues, launched a survey on Perinatal Mental Health on 08 November to inform the development of a guidebook for new parents, which aims to bring awareness around perinatal mental health issues and offer guidance and support.
    - reviewing father/partner mental health support with Mental Health and Mind Jersey with a view to implement UK initiatives.
- Birthrate Plus team have visited and collated data. The Birthrate Plus acuity tool is essential for understanding the midwifery workforce requirements and development of a workforce strategy. Maternity Services are awaiting their final report.
- An external expert obstetrician (Dr Devender Roberts) has been engaged to advise on the programme of work and provide regular peer review scrutiny and expertise to the Interim Chief of Service, their latest review was undertaken on 08 – 10 November and focused on strengthening governance arrangements for the division, review of obstetric theatres and review of the gynaecology service provision. A full report is pending.

Key actions for December:

- Commencement in post of the substantive Director of Midwifery, who will support the development of the Maternity Strategy
- Picker Institute due to survey Maternity Services in December 2023. Maternity Services received excellent results from the survey completed in 2022. The Picker patient experience survey lead the development of patient experience measures as a way of understanding the quality of person-centred care from the patient's perspective.

Progress to date

Currently 80 out of 127 recommendations have been identified by Women and Childrens Senior Leadership Team as complete (up from 70 in October), of which 68 have been confirmed as having robust evidence/ business-as-usual process. 12 are under review to ensure robustness of evidence and sustainability of any business-as-usual processes.

High level progress to date can be found below:

Total Number of recommendations	September	October	November
	127	**127**	**127**
Complete signed off	42	55	68
Complete	15	15	12
Green	11	23	17
Amber	56	31	27
Red	3	3	3

High level information of the red recommendations can be found below, each of these has been discussed with an agreed mitigating action at the Maternity Improvement Plan Monitoring Meeting (MIPMM) on 22nd November. A detailed breakdown of these can be found in the attached exception report.

Rec.ID#	Subject matter	Exception	MIG Outcome
004	Maternity Culture Strategy	Identified as red due to the progress to be made with staff and improving psychological safety.	Recommendation to remain red. A Culture improvement plan timeline has been discussed and approved to be implemented, led by the Director of Culture, Engagement and Wellbeing.
101	Staff who work together must train together	Identified as red due to lack of multidisciplinary working.	Recommendation to remain red, it is noted that the service have commenced skills and drills.
161	Regular multi professional development and training.	Identified as red due to slow progress in establishing programme of multi-disciplinary learning. First skills and drills session held on 20/11/2023.	Recommendation to remain red. This recommendation has close ties with the Culture recommendation.

Ongoing priorities

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

Maternity Improvement Plan - transfer to business-as-usual

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

It is recognised that new areas for improvement will be identified through governance processes, making it important to define mechanisms to ensure that the learnings and method from the MIP continues and is embedded into the routine governance processes for the division. Consideration will need to be given to how this is supported; at present the project management support provided to the MIP has been fundamental to realising improvement.

3. Finance / workforce implications

Finance

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

- Rec.004 Culture

- The Culture, Engagement and Wellbeing Team have established a comprehensive programme for cultural initiatives to be implemented. Some elements of the programme require funding for which final costs are yet to be determined and will be shared at the MIP Monitoring Meeting for approval.

Workforce:

- Rec.041 Workforce
  - Birthrate Plus team have visited and collated data. The Birthrate Plus acuity tool is essential for understanding the midwifery workforce requirements and development of a workforce strategy. Maternity Services are awaiting their final report.
  - It is anticipated that some increase in workforce may be required to optimise services, and this is being formally tested with a validated external assessment (Birthrate Plus).
- Practice Development Midwife
  - Women and Children's were unsuccessful in their appointment to this role, and interest for a secondment to this post is being ascertained.
- There are challenges in the recruitment and retention of clinical staff across the department which impacts on the process of embedding changes.

4. Risk and issues

It is recognised that significant culture change is required to ensure sustained improvement and continuation of the plan recommendations beyond the current programme. This is being addressed in the culture and workforce workstreams of the plan in collaboration with the Director of Culture, Engagement and Wellbeing.

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

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

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

5. Applicability to ministerial plan

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

6. Main Report

A detailed recommendation exception report is attached that outlines going issues experienced regarding culture and multi-professional training and development for which Maternity Services are focusing on as they near the final recommendations of the MIP.

During 2023 Maternity Services have been dedicated to ensuring the MIP is successful with sustained improvements and have been able to evidence 80 out of 127 recommendations to date, with themes focusing on family and staff voices, Maternity Refurbishment, perinatal mental health, infant feeding and policies and guidelines.

Maternity Services are cognisant that the pace needs to remain for 2024 where the focus will be on improving culture, multidisciplinary training and competencies.

7. Recommendation

The Board are asked to note the content of the cover report and attached recommendation exception report, acknowledge the ongoing progress of completion and assurance of embedded practice, and recognise the challenges which remain regarding ongoing cultural issues.

END OF REPORT

Maternity Improvement Plan

November 2023

What is the Maternity Improvement Plan?

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

Perinatal Mental Health midwife Josephine Lane (left) and Jersey Maternity Voices Partnership Chair Emma Sykes

What has progressed in November?

- 80 completed recommendations out of 127 (up from 70 in October)
- Gynae outpatients has commenced in Minor Ops
- Perinatal Mental Health Midwife launched survey for parents to support the delivery of perinatal mental health workbooks, in collaboration with multi-agency colleagues
- Online PROMPT training dates confirmed with staff scheduled to attend
- Ongoing review of partner mental health support and pathways
- Maternity Support worker day held on 24 Nov where staff received a gift and tea party
- Reception Desk and Ward Entry are undergoing refurbishment

What's happening in December?

- Viscount visit to Care Group Governance meeting to discuss legislation 01/12
- Roslyn – Substantive Director of Midwifery – due to commence 11/12
- Picker Institute to survey Maternity Services following excellent results from the 2022 survey
- Outcome report of Birthrate Plus review
- New Infant Feeding page on gov.je

Your voice

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

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

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

Health and Community Services

Maternity Improvement Plan Exception Report

November 2023

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, for attention of the HCS SLT Change Programme Board.

Introduction

The Maternity Improvement Programme was established on 28th June 2023, the purpose of the programme is to deliver coordinated and sustained improvements within Maternity to address the recommendations from internal and external reports which have received and been within the organisation since 2018, with clear assurance and accountability. This includes reviews of maternity services in the UK with included recommendations of relevance to quality improvement in obstetric and maternity care.

The programme aims to consolidate the themes and actions within the plans in addition ensuring that the responses become part of the embedded business-as-usual governance process of the organisation, with a sustained, lasting improvement in Jersey Maternity Services.

Governance Arrangements

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

High level progress to date

Escalation Standards

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

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

Total Number of recommendations	September	October	November
	127	**127**	**127**
Complete signed off	42	55	68
Complete	15	15	12
Green	11	23	17
Amber	56	31	27
Red	3	3	3
Escalate	0	0	0
Not started	0	0	0

Not Started – Work to deliver against recommendation has not started

Escalate – To be escalated to MIPMM or WACs SLT

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

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

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

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

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

Rec. ID#	004
Report	Scrutiny Report
Recommendation Description	The Minister for Health and Social Services must ensure that the Local Committee, developed following the initial Culture Summit, includes multi professional and across sector representation and that the Culture Strategy is published as an integrated part of the Maternity Services Strategy. Furthermore, the Culture Strategy should be a statement of the overarching values of the maternity service and the behaviours that will underpin those values. [page 41]
Progress to date and cause of the exception and impacts	Drop-in listening sessions, led by the Director of Culture, Engagement and Wellbeing and Bev Edgar (Change Team) have been held with maternity staff over August. The 2018 culture plan has been provided to the Culture and Engagement Team. The findings from this were discussed at MIPMM 13/09/2023. The drafted Maternity Culture Plan was presented to MIPMM on 11/10/23 where it was requested that an associated programme of activity presented to the Maternity Improvement Group, following further listening sessions. A timeline of culture events and support the Maternity Culture Plan was presented to the MIPMM on 08/11/2023 which was approved to be implemented, led by the Director of Culture, Engagement and Wellbeing. This plan includes support from the Civility Saves Lives programme from 2024, with an associated cost to be confirmed at the MIPMM. To date listening sessions have been held with Maternity staff with known difficulty engaging with consultants. It has been suggested to establish a benchmarking questionnaire for maternity staff that could be used to evidence progress made in culture. It is noted that the ability to train together as a multi-disciplinary will support improvements in working relationships, this links into red recommendation 161. This recommendation has been identified as red due to the progress to be made with listening sessions with staff, to lead into a programme of activity.
Raised at MIPMM	09/08/2023, 23/08/2023, 13/09/2023, 20/09/2023, 27/09/2023, 11/10/2023, 18/10/2023, 25/10/2023, 08/11/2023, 22/11/2023
MIPMM Outcome	It was agreed at MIPMM 08/11/23 for this recommendation to remain red, and for the timeline of culture events to commence and findings to be discussed at each MIPMM.

Rec. ID#	101
Report	Ockenden
Recommendation Description	Staff who work together must train together.
Progress to date and cause of the exception and impacts	This recommendation has been identified as red due to the lack of multidisciplinary working and difficulty establishing multi-professional training as seen in Rec.ID#161.
Raised at MIPMM	08/11/2023, 22/11/2023
MIPMM Outcome	It was agreed at MIPMM 08/11/23 for this recommendation to remain red until a series of multi-professional working can be committed to and measured improvement regarding the culture in Maternity.

Rec. ID#	161
Report	JMASS
Recommendation Description	Standard 15 15.25 There should be regular multi professional development and training, including obstetric and neonatal resuscitation and emergencies, and CTG interpretation, by all who are involved in intrapartum care of the woman and her baby. This training and development should occur in realistic settings.
Progress to date and cause of the exception and impacts	It is noted that this recommendation links closely with the Culture recommendation due to relationships between multi professionals. Effort has been made to establish a session of multi-disciplinary learning, to be held in October/November however progress remains slow. The first multi-professional skills and drills session was held in Maternity on 20/11/2023. A programme of multi-professional training is under establishment. This recommendation has been identified as red due to the current culture within Maternity.
Raised at MIPMM	11/10/2023, 18/10/2023, 25/10/2023, 08/11/2023, 22/11/2023
MIPMM Outcome	It was agreed at MIPMM 08/11/23 for this recommendation to remain red until a series of multi-professional working can be committed to and measured improvement regarding the culture in Maternity.

Health and Community Services

Health and Community Services Advisory Board Report

Report to:	Health and Community Services Advisory Board		
Date of meeting:	6th December 2023		
Title of paper:	Infection Prevention and Control (IPAC) Report		
Report author (& title):	Dr Ivan Muscat, Consultant Microbiologist and Director of Infection Prevention and Control and Janice Byrne, Lead Nurse IPAC	**Accountable Executive:**	Jessie Marshall Interim Chief Nurse

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board? *(brief statement & tick as appropriate)* *Any pre-reading*	To provide the Advisory Board with an overview of the status as of the end of October 2023 of the Flu and COVID 19 Vaccination Programme.	Information	
		Decision	
		Assurance	Yes
		Update	Yes

2. Executive Summary

Staff vaccinations are critical in reducing the spread of flu during winter months. Health and Community Services (HCS) flu and COVID vaccination is part of the overall measures to reduce the burden of these infections on secondary care.

3. Finance / workforce implications

a. Funding of team to deliver Flu and COVID vaccination programme.
b. Incentives to staff to vaccinations
c. Data inputting - no IT system

4. Risk and issues

a. Reduced ability to support HCS.
b. Poor uptake of the vaccine, magnified recently by vaccine fatigue in staff (and the general public)

5. Applicability to ministerial plan

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

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

6. Main Report

Vaccination rates Flu/Covid

Staff vaccinations are critical in reducing the spread of flu and Covid 19 during winter months, protecting those in clinical risk groups and reducing the risk of contracting both flu and Covid 19 at the same time and the associated outcomes and reducing staff absence and the risk for the overall safe running of HCS services.

The HCS staff vaccination programme is carried out yearly by a team of nurses who have received the relevant training, several activities are being deployed including peer to peer vaccination, working alongside Public Health, Government of Jersey. Staff are offered a free tea or coffee as an incentive.

The overall target is to ensure at least 75% HCS staff are vaccinated in line with the UK. This year's campaign is located in a room next to the hospital canteen to ensure greater visibility.

Below is the uptake of HCS Flu and COVID vaccination to 16th November 2023. Only HCS staff who have been vaccinated on HCS premises or who have attended Fort Regent vaccination clinic are captured in these figures. Those who attend their GP or pharmacies are not captured. (expectation that the latter is more likely to include immunocompromised individuals; < 5% of the general population is considered immunocompromised).

Overall uptake is low, although COVID uptake is better than last year. This position is also reflected across other government departments and across the UK. Staff communication is set out weekly including location and timing of static and mobile clinics, covering sites both inside and outside the hospital. Staff at ward level are reminded daily of the static clinics that run between 8.30 and 3.30 and set up clinics to cater for night shifts. Notices are present at the entrances to the hospital. The programme will continue to run until the end of December 2023. It has become clear that staff do prefer to have co vaccination.

Total Number of Flu & COVID Staff Vaccinations given in HCS Total to date 16/11/23			
Vaccination	**Total**	**Average Percentage of staff (3,200)**	**Final December 2022 (Average percentage staff 3,500)**
Flu	**986**	**31%**	**34%**
COVID	**815**	**25%**	**14%**

Conclusion

Staff vaccination against COVID and flu support HCS resilience. It is supported by the overall response to these infections which includes vaccination of all eligible groups which includes all children in relation to flu (children are superspreaders of flu) as well as early diagnosis of infection permitting early isolation and appropriate treatment.

Recommendation

The Advisory Board is asked to note the contents of the report, support the ongoing work of the IPAC team, support the uptake of Covid and Flu vaccination across the board and support more efficient data collection including feedback from GPs to improve our statistics.

Health and Community Services

Health and Community Services Advisory Board Report

Report to:	Health and Community Services Advisory Board		
Date of meeting:	6th December 2023		
Title of paper:	Freedom to Speak Up Guardian - update		
Report author (& title):	Ashling Mc Nevin (Freedom to Speak Up Guardian)	**Accountable Executive:**	Chris Bown Chief Officer

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board?	To support and inform the successful delivery and development of a Freedom to Speak Up Culture across HCS.	Information	√
		Decision	
		Assurance	
		Update	√

2. Executive Summary

This report will,

- provide an overview of employee contacts made to the Freedom to Speak Up Guardian.
- identify categories and themes of concerns raised within Health and Community Services (HCS).

3. Finance / workforce implications

Staff to be supported to undertake the Speak Up module as part of the National Guardians Office training.

A budget is required to fund the National Guardians Office training on Speaking Up.

4. Risk and issues

Risk to staff wellbeing which will potentially impact performance and therefore patient safety.

5. Applicability to ministerial plan

6. Main Report

The Freedom to Speak Up Guardian (FTSUG) within Health and Community Services became an active role at the end of January 2023. The role of the FTSUG in Jersey sits outside for the National Guardian's

Office (NGO) but local practice aligns to NGO Guidance regarding performance, case recording and reporting of data. The NGO require information to be categorised under the following headings:

- Patient safety / quality
- Worker safety / wellbeing
- Bullying / harassment
- Other inappropriate attitudes / behaviours

From end of February 2023 to date (23rd November 2023), the FTSUG has been contacted by 63 individuals across the organisation. Those who have come forward to raise concerns are from numerous professions and worker groups within the organisation.

The following information outlines the number of cases which have been brought to the FTSUG and highlights the required categories. Most cases have elements of all the above categories.

The concerns raised will inform the HCS cultural change plan for 2024.

Of the concerns brought forward:

- 25 had a patient safety/quality element.
- 32 were related to worker safety/wellbeing.
- 25 had elements of bullying /harassment.
- 31 involved other inappropriate attitudes or behaviours.

Four members of staff reported that prior to the FTSUG being in post, they had previously experienced disadvantageous/demeaning treatment due to speaking up.

Of the 63 contacts made to the FTSUG, 14 have been investigated and closed. The outcomes following these investigations has highlighted:

- opportunity for organisational learning
    - identified inconsistencies in practice and processes.
    - organised listening events with colleagues to discuss ways forward.
    - improvements made to processes e.g. for Health Care Assistants -
        - re-introduction of different colour uniform for new Health Care Assistants (HCA's) to ensure staff were aware that they were undertaking shadow shifts.
        - HCA's will receive three full days of orientation with the wards being informed that they must not work unsupervised.
        - There will be a named HCA for orientation which has been confirmed by the ward manager.
        - Enhanced care course will be offered as near as possible to completion date of shadowing shifts (this will be paid study).
        - The temporary staffing office will undertake a monthly review meeting with all new bank HCA's.
        - A review and update of the orientation booklet is underway.
        - A list of all HCA's undertaking shadow shifts will be shared with the practice development nurse so that they can visit the wards.
    - need for a cultural work plan to address attitudes and behaviours across HCS.

- positive outcomes for the reporting member of staff with improvements being made which directly impacts them in their working day.

- Positive action taken has resulted in senior leaders addressing reported poor behaviour directly with those who were perceived to be demonstrating it. Where this has happened there has reportedly been a reduction in the behaviour causing offence.

At time of writing seven reports are being reviewed by the individuals who raised the concern.

There are 25 cases active and open which have been forwarded on to identified senior leaders to review and investigate. As some of the cases reported have numerous aspects to them, they have remained open for extended periods of time. The longest case open dates to initial contact being made with the FTSUG in April 2023.

There is a requirement on those who have been identified as investigators to update the FTSUG on progress so this in turn can be fed back to the reporting member of staff (RMoS). The process for providing routine feedback to the FTSUG on what action will be taken to resolve issues raised could be improved as at times this is inconsistent and most often requires the FTSUG to initiate the request for an update on progress.

The FTSUG has had contact with 17 individuals who later chose not to pursue their concerns. Some of these reports were addressed directly within their departments or with their line managers. Several employees did not respond to the FTSUG following the initial meeting and report being sent to confirm accuracy, despite numerous attempts to make contact being made by the FTSUG. Employees are made aware that issues will not be taken forward for investigation without confirmation of accuracy being received by the FTSUG. These cases were later closed as a result. It is difficult to determine why employees later chose not to pursue their concerns, although fear of consequence / retribution against the person raising the concern cannot be ruled out (if pursued). The FTSUG believes it unlikely the concern ceased to exist.

Please note, where there was a patient safety / quality issue, this was not a direct patient safety issue / concern. It was linked to behaviour, the impact of such on employees and the further impact of this on patient quality / safety.

Of those not taken forward:

- 5 had elements of patient safety.
- 6 were related to worker safety / wellbeing.
- 7 highlighted issues relating to bullying/harassment.
- 9 identified other inappropriate attitudes or behaviours.

Individual feedback directly to the FTSUG from those who have accessed the support of the FTSUG service include:

Cases taken forward and investigated:

“a great result for me and many thanks and much appreciation for your help”.

“I am really grateful that you helped me work it through in my head and to move on from it, and also it shows how valuable your role is because it made a difference to both me and [. . .]”.

“We are very grateful for your help, and support, and we are also happy with the outcome”.

“I would say it’s very vague and doesn’t take any ownership of any issues I have experienced. It lacks substance and I am really considering leaving [. . .} in the near future as there is so little being learned from the feedback of people like myself. I now lack trust that this organisation has my best interests at

heart. I don't feel this really has made any benefit to me personally".

Issue not taken forward, but contact benefitted the individual:

"I am just emailing you to let you know I am feeling much better after we talked. I didn't realise how important it was for me to be able to speak honestly and openly to someone who represents my employer. It was not a therapy session but I can tell you it was more therapeutic for me than I thought. For that, I am forever grateful. I am more optimistic moving forward knowing there is always a safe place where we can openly speak about our problems without being judged. I must say I have been around encouraging others to speak with you when and if needed".

7. Recommendation

The Board are asked to note the report.

The Board is also asked to note that a proposal will be taken to the HCS SLT regarding the Speak Up module within the National Guardian's Office – Speak Up, Listen Up, Follow Up training course for HCS colleagues.

END OF REPORT

Health and Community Services

Health and Community Services Advisory Board Report

Report to:	Health and Community Services Advisory Board		
Date of meeting:	6th December 2023		
Title of paper:	HCS Culture Change Plan		
Report author (& title):	Cheryl Power Director of Culture, Engagement and Wellbeing	**Accountable Executive:**	Chris Bown, Chief Officer

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board?	To provide an update and overview to the Health Board of the HCS culture change plan and activity	Information	√
		Decision	
		Assurance	√
		Update	√

2. Executive Summary

HCS depends on its workforce to deliver high quality and safe patient care. Robust evidence indicates a positive workplace culture enables better patient outcomes, high performing multi-professional teams, improved psychological safety, staff retention and reduced incidents of clinical errors.

3. Finance / workforce implications

The release of staff from all parts of HCS to engage in the cultural change programme.

A budget is required roll out all elements of the culture change programme.

4. Risk and issues

Working in a culture that does not promote inclusiveness, does not work collaboratively together as a team and does not create an experience of psychological safety can reduce all staff to give their best and ultimately compromise patient care. In short, a poor culture can lead to poor care.

5. Applicability to ministerial plan

Implementing the culture change plan and the necessary cultural initiatives will create the conditions which champion development of a healthy and positive working culture in which HCS staff feel they are valued team members working together to meet patient's needs and that they are free to speak up about any concerns they have. The plan will enable a platform for the necessary reform of HCS's internal governance structures that drive learning and continuous improvement and support an engaged and productive workplace environment by listening and engaging with staff.

6. Main Report

Evidence from several sources including Freedom to Speak Up activity, BeHeard engagement survey data, HCS staff wellbeing activity and complaints data demonstrates we are facing cultural challenges within HCS. The following cultural issues have been identified.

- Fear of escalating concerns resulting in not having a voice
- Leaders and managers not truly living the values of the organisation.
- Bullying / harassment / inappropriate behaviours within the workplace environment.
- No consequences perceived when people behave inappropriately.
- Limited opportunities to learn, innovate and grow within the organisation.
- Poor psychological safety within teams.
- Ineffective team working.
- Limited collective multi-professional decision making.
- Low morale and a wish to feel more valued.

To address the identified challenges, a culture change plan (appendix 1) has been developed that recommends a number of evidence-based cultural programmes and activities to be implemented within HCS.

1. Civility Saves Lives

Civility Saves Lives is a programme specifically for healthcare professionals aiming to raise awareness of the power of civility in medicine and its specific impact on patient/client care outcomes. Incivility is anything ranging from rude or unsociable speech or behaviour. When someone is rude it reduces our ability to effectively manage multiple tasks and conscious thoughts such as chasing blood results, ordering investigations and being able to consider differential diagnoses. Rudeness reduces our ability to do our jobs effectively and safely. Health care teams perform worse in the presence of rudeness. Research has found a negative impact on clinical outcomes such as an increase in diagnostic and procedural errors when health care professionals are exposed to rudeness (Risken, A et al. *The impact of rudeness on clinical team performance*. Paediatrics. 2015 Sep; 136(3):487-95). When we condone rudeness in our teams, we accept poorer outcomes for our patients/clients.

2. Developing a Restorative Just and Learning Culture

The fair treatment of people working in a health and social care setting supports a culture of fairness, openness and learning by enabling staff feel confident to speak up when things go wrong, rather than fearing blame. Committing to a restorative just and learning culture within HCS will drive forward a work environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. This is a culture that focuses on asking ‘what was responsible, not who is responsible’. Embedding just and learning principles within HCS will support staff to be open about mistakes and allow valuable lessons to be learnt so the same errors can be prevented from being repeated.

3. Psychological Safety in Teams

Psychological safety is about having trust in our leaders, managers and our team. Everything we do for our patents/clients in HCS requires teamwork. Good teams perform better, and this leads to better outcomes. Feeling valued and respected as part of the team matters. Evidence states when health staff perceive themselves to be in a good team there is reduced patient complaints, improved staff satisfaction, improved staff performances and better health of staff (West M A & Dawson J F (2012) *Employee Engagement & NHS Performance survey*. London: The Kings Fund).

Delivering Psychological Safety in Teams workshops will encourage staff to feel safe in using their knowledge and skills to make a meaningful contribution. When you feel safe you can speak up and challenge the status quo.

4. Leadership and management development

Developing the right people with the right skills and the right values is recognised as essential to enable the sustainable delivery of health services. The way we lead and manage significantly influences how we shape our culture within HCS. Ensuring the right leadership and management behaviours and qualities across all levels in all areas are developed will enable HCS to drive forward a well-led, well-managed positive culture.

5. Wellbeing support

Continuing the comprehensive programme of wellbeing support for all HCS staff will provide rapid wellbeing support where needed.

6. Regular feedback through listening events and pulse surveys

Evidence indicates that engaged staff deliver better care with better patient/client experience, fewer errors, lower infection and mortality rates, higher staff morale and motivation. By contrast, when staff engagement is poor it can lead to demoralised staff resulting in poor quality and potentially unsafe patient care (Ham C. Improving NHS care by engaging staff and devolving decision-making. London: The Kings Fund 2014). Continuing the feedback opportunities for staff within HCS to raise issues and frustrations will support staff engagement.

7. Recommendation

The Board is asked to note the report.

END OF REPORT

HCS People and Culture Plan - 2024

Term of Reference	Goals	Actions/Objectives	Owner (who)	Delivery date	Expected outcomes (success measures)	What will it look/feel like for HCS staff How will it be different	Outcome (RAG status)
Our Culture	Always putting the patient/client at the centre of what we do. Work environments are respectful and promote inclusiveness enabling safety to share information. Improve multi-professional team working and collective decision making, escalating concerns when needed. Create better opportunities to safely learn and innovate and improve following incidents. Develop opportunties to safely reflect on professional practice	1. Deliver targeted organisational development diagnotics to understand cultural needs and implement a series of cultural programmes; 2. Continue to embed Freedom to Speak Up activity. 3. Launch Civility Saves Lives Behaviour Matters (CSL). 4. Introduce a restorative just learning approach particulalry following a serious incident. 5. Deliver psychological safety in teams. 6. Enable coaching to help staff respond appropriately in emotionally charged interactions.	Director of Culture, Engagement and Wellbeing	1. Commenced in August 2023 and ongoing throughout 2024 2. Commenced in January 2023 and ongoing throughout 2024. 3. CSL to be launched in January 2024 and continue embedding alongside other cultural interventions throughout 2024. 4. Quarter 2/3 2024 5. Corporate Psychological Safety in Teams trainnig to commence Q1 2024 with Maternity services	Freedom to Speak Up activity. Reduced dignity & respect grievances. Decrease in sickness absence where data reports absence as anxiety/stress/depression. Improved learning following an incident Improved reflective practice	Staff feel able and safe to escalate concerns and have views respectfully challenged. Staff feel psychologically safer in the work environement and within their team particularly when making decisions Staff experience improved work relationships and feel empowered to work together Staff experience a culture of helpfulness, value & belonging Staff experience a non-blaming work environment, Staff feel a sense of ownership of their work	
Leadership and Management Development	Our Values, Our Behaviours are visible and demonstrated throughout all levels of leadership & management. Leaders have clear leadership objectives Managers are developed and invested in through formal qualifications/GoJ manager training/mentoring	1. Executive Leadership to undertake leadership and management development, to support their teams in delivering sustaintable models of high-quality care. 2. Corporate team to deliver core leadership training programme to General Managers, Clinical Leads, Lead Nurses, Lead AHP's etc. 3. Identify Short/Medium/Long Term plan for all middles management development including partcipation in World Class Manager sessions.	Director of Culture, Engagement and Wellbeing	1. Quarter 2 2024 2. Quarter 2 2024 and ongoing throughout 2024 3. Quarter 2 2024	Improved performance (managers responding to issues) Increase in Connect Performance retirns (with SMART objectives and progress) Reduced number of dignity & respect grievances	All leaders and managers will know our values and behaviours and feel eqipped with skills to handle inappropriate behaviours, difficult conversations, and how to develop staff.	
Engagement and Communication	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. Improve engagement & communication, including understanding HCS purpose, the strategic plan and care group/service priorties. Ensure the communications for the HCS People & Culture plan & the individual care group People & Culture plans are connected & aligned to HCS vision and objectives.	1. 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. 2. Develop & implement quarterley Pulse Surveys.	Director of Culture, Engagement and Wellbeing and Head of Communications	1. Ongoing throughout 2024. 2. Quarterley pulse surveys to commence January 2024	Increased staff engagement Improved staff collaboration & connection Smarter decision making Improved performance	Staff feel their voice is heard and connected to all levels of leadership, staff feel they can contribute to ideas and improvements	
Diversity & Inclusion	Create a D&I plan for HCS	1. Working Group has been created to develop anti-racism statement for HCS. Use working group to develop wider strategy, plan & key deliverables	Director of Culture, Engagement and Wellbeing and REACH Lead	1. Anti-racisim statement to be lauched alongside Civility Saves Lives programme Quarter 1 2024	D&I plan Reduced numbers of dignity & respect grievances Improved workplace relationships	Staff feel a sense of belonging, connected and productive within HCS, all staff feel valued equally	
Well Being	Continue wellbeing support for colleagues across HCS aligned with NICE guidance; 'Mental Wellbeing at Work', March 2022	Use established Culture, Engagement & Wellbeing committee to create & develop plan & key deliverables	Director of Culture, Engagement and Wellbeing	Ongoing throughout 2024	Increase in wellbeing engagement factors Reduced sickness absence rates Reduced anxiety/stress related absence Improved performance	Staff experience good working relationships Staff report an improved work/life balance Staff experience less stress & burnout and improved physical & mental wellbeing	
Strategic Workforce Plan	Produce a strategic workforce plan for HCS	1. Ensure engagement with PCS strategic workforce plan team at Care Group and Exec level 2.	Care Groups SLT, HRBP	Jan-24	Understanding of emerging capabilitites and skill requirements Development of a plan to meet future needs and mitigate risk Identification of areas requiring succession planning and training requirements	Engagement of workforce with future plans	
Recruitment	Increase number of substative employees Reduce reliance on agency and locum workers	1. Continue the mutli approach method to recruitment 2. Develop recruitment pipeline metrics 3. Engage with apprenticeship and internship programmes	AD of HR, PMO	Ongoing throughout 2024	Reduced vacancy numbers and reduced agency numbers Increased numbers of interns and apprentices	More staff in post	

Connect People	Maixmise Usage of Connect across HCS	1. increase usage of Connect Performance through 2024 2. Uitlise Connect Learning for delivery and recording of training 3. Implement Connect People (Employee Central) for managers 4. Implement Talen Acquistion for hiring new recruits	AD of HR,	Ongoing throughout 2024	1. Increased number of colleagues with recorded objectives and appraisals 2. Ability to record and report training compliance 3. All staff changes completed via Employee Central 4.Quicker time to hire	Regular conversations between managers and team members Assurance that training is being carried out Less paperwork in relation to staf changes Candidate experience will be better	
Support the work of 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	AD of HR,	Ongoing throughout 2024	Resolution of matters where possible	Increased confidence from the HCS workforce that issues are taken seriously and resolved.	