# Government of Jersey – Health and Community Services
# Health and Community Services (HCS) Board

TEAMS

8 March 2021 14:30 - 8 March 2021 17:00

# ATTENDEES

| | |
|---|---|
| Adrian Noon<br>Medical Director Primary Care / Associate Medical Director Primary, Prevention and Intermediate Care | Accepted |
| Andrew Carter<br>Performance Analyst | Declined |
| Anuschka Muller<br>Director Innovation and Improvement | Accepted |
| Beverley Edwards<br>Head of Informatics HCS | Unconfirmed |
| Bronwen Whittaker<br>CEO Family Nursing and Home Care | Accepted |
| Caroline Landon<br>Director General HCS | Accepted |
| Emma O'Connor<br>Interim Board Secretary | Accepted |
| Gail Caddell<br>Deputy CEO Jersey Hospice Care | Unconfirmed |
| Hugh Raymond<br>Assistant Minister for Health and Social Services | Accepted |
| Isabel Watson<br>Assocaite Managing Director Mental Health Services and Adult Social Care | Accepted |
| Martyn White<br>Head of Communication HCS | Unconfirmed |
| Matthew Doyle<br>General Practitioner | Accepted |
| Michelle Roach<br>Head of Finance HCS | Accepted |
| Patricia Tumelty<br>CEO Mind Jersey | Declined |
| Patrick Armstrong<br>Group Medical Director HCS | Declined |
| Richard Renouf<br>Minister for Health and Social Services | Accepted |
| Robert Sainsbury<br>Group Managing Director | Accepted |
| Rose Naylor<br>Chief Nurse | Accepted |
| Ruth Brunton<br>CEO Brighter Futures | Accepted |

| | |
|---|---|
| Sam Lempriere<br>Management Executive Support | Declined |
| Steve Graham<br>Associate Director of People | Accepted |
| Trevor Pointon<br>Assistant Minister for Health and Social Services | Accepted |

# AGENDA

| # | Description | Owner | Time |
|---|---|---|---|
| 1 | Welcome and Apologies<br>Verbal | Chair | 2:30pm |
| 2 | Declarations of Interest<br>Verbal | Chair | 2:35pm |
| 3 | Service-User Story<br>This item has been deferred. | | |
| 4 | Professional's Story: UNICEF BFI Initiative<br>Presentation | Sarah Keating | 2:40pm |
| 5 | Minutes of the previous meeting<br>Minutes of 15th February 2021<br>ITEM 5. HCS Board Minutes 15022021.docx 9<br>ITEM 5b. Professional Story.pptx 21 | Chair | 2:55pm |
| 6 | Matters Arising and Action Log<br>Verbal / Paper<br>ITEM 6. Action Tracker.xlsx 29 | Chair | 3:00pm |
| 7 | Chair's Report<br>Verbal | Chair | 3:15pm |
| 8 | Director General's Report<br>Verbal | Director General | 3:25pm |
| 9 | View from the Bridge<br>•Family Nursing and Home Care<br>•Jersey Hospice Care<br>•MIND Jersey<br>•Dementia Jersey<br>•General Practice<br>• Brighter Futures | Partner Organisations | 3:35pm |

| # | Description | Owner | Time |
|---|---|---|---|
| 10 | Committee Report: Quality Peformance and Risk<br>Paper<br>ITEM 10. QPR Feb 2021 final.docx 31 | Chief Nurse | 4:05pm |
| 11 | Committee Report: Operations, Performance and Finance Assurance Committee<br>Paper<br>ITEM 11. HCS Board Report_FOP Ctte_March_202... 35 | Director Innovation and Improvement | 4:15pm |
| 12 | Committee Report: People and Organisational Development<br>Paper - To Follow | Associate Director of People HCS | 4:25pm |
| 13 | Jersey Care Model Governance Framework<br>Paper / Presentation<br>ITEM 13. HCS Report - JCM Governance Framewo... 37 | Programme Manager | 4:35pm |
| 14 | Advanced Clinical Practice Framework<br>Paper / Presentation<br>ITEM 14. Advanced Clinical Practice Framework P... 43<br>ITEM 14a. Appendix 1 ACP Framework Jersey V1... 47<br>ITEM 14b. Appendix 2 PEPPA Model Advanced Cli... 69<br>ITEM 14c. Appendix 3 ACP Job Description Jan 21... 71 | Associate Chief Nurse (Professional Practice) | 4:45pm |
| 15 | Any Other Business<br>Verbal | Chair | 4:55pm |
| 16 | Date of Next Meeting TBC<br>TBC | | |
| 17 | Meeting Closed | | 5:00pm |

# INDEX

# Health and Community Services Board
## Notes of meeting on Monday 15 February 2021 3:00pm – 5:00pm
## 3rd Floor (Corporate Office), Peter Crill House, St. Helier and via Teams

| | | | |
|---|---|---|---|
| **Present:** | Richard Renouf (Chair) | Minister for Health and Social Services | RR |
| | Trevor Pointon | Assistant Minister for Health and Social Services | TP |
| | Hugh Raymond | Assistant Minister for Health and Social Services | HR |
| | Caroline Landon | Director General | CL |
| | Robert Sainsbury | Group Managing Director | RS |
| | Rose Naylor | Chief Nurse | RN |
| | Anuschka Muller | Director of Innovation & Improvement | AM |
| | Michelle Roach | Head of Finance Business Partnering HCS | MR |
| | Adrian Noon | Associate Medical Director for Primary, Prevention & Intermediate Care deputising for Patrick Armstrong | AN |
| | Isabel Watson | Associate Group Managing Director Adult Social Care & Mental Health Service | IW |
| | Ruth Brunton | CEO – Brighter Futures | RB |
| | Patricia Tumelty | CEO – Mind | PT |
| | Gail Caddell | Deputy CEO Jersey Hospice Care | GC |
| | Martyn White | Head of Communication HCS | MWh |
| | Nicola Cabral | HR Manager HCS deputising for Steve Graham | NC |
| **In Attendance:** | Emma O'Connor | Interim Board Secretary | EOC |
| | Sam Lempriere | MEX Support Lead | SL |
| | Andrew Carter | Governance & Performance Analyst | AC |
| | Beverley Edwards | Head of Informatics HCS | BE |
| | Jenna MacKay | Rayner Ward Manager (Item 1-4 only) | JMK |

**Please note:** *Minutes have been numbered in accordance with Agenda. Some items have been taken out of order.*

| | | Action |
|---|---|---|
| **1.** | **Welcome and Apologies**<br><br>RR opened the HCS Board and welcomed all to the meeting. Apologies were given for the rescheduling of this due to States Assembly commitments.<br><br>Patrick Armstrong – Group Medical Director – Clinical Commitments<br>Steve Graham – Associate Director of People HCS – Annual leave<br>Sean Pointon – CEO Jersey Alzheimer's Association<br>Bronwen Whittaker – Quality and Governance Lead, Family Nursing and Home Care – IT Issues<br>Ruth Brunton – CEO Brighter Futures – Prior Commitment<br>Matthew Doyle – General Practitioner – Work Commitment | |
| **2.** | **Declarations of Interest**<br>No declarations of made | |
| **3.** | **Service-User Story**<br>This item has been deferred until the restrictions have reduced as service-users are requesting to deliver their story in person. | |

| | | |
|---|---|---|
| **4.** | **Professional's Story**<br>RR welcomed J. MacKay (JMK), Ward Manager Rayner, to the meeting. JMK advised the Board that she was going to present her experience during the surgical redeployment 2020, with a particular focus July–October. A slideshow presentation followed (slides annexed to these minutes). JMK provided an overview including,<br><br>• How the need for redeployment arose<br>• Support & training provided to staff<br>• Sharing of ideas and changes made<br>• Patient pathway changes<br>• Positive experience<br>• Barriers overcome<br><br>RR thanked JMK for the presentation & asked how long the redeployment period lasted for. JMK stated she transferred for 3 months and by mutual agreement transferred back. However, the deployment of some nursing staff continues. The redeployment will suspend in March 2021 to provide staff with a permanent base. RR asked if anything additional can be done to embed this joint working. JMK responded that a lot of work was done to overcome the initial challenges and it would be wrong to suspend the redeployment completely and then potentially have to face the same challenges in the future. One possible solution would be to continue redeployment as part of a structured programme.<br><br>CL thanked JMK for this work & stated that this demonstrated the agility and enthusiasm of staff. CL asked if staff overall enjoyed the experience & the new challenges they were faced with. JMK stated at the time staff were keen to learn new skills but there was anxiety around transferring to a different environment, however this soon settled. CL asked if JMK had enjoyed the experience as a leader as this presents opportunities to explore how this type of working could continue in the future.<br><br>RN thanked JMK & stated that this was an excellent example of the work across surgery, supporting staff with competency and development. RN asked JMK if she had not been in the Band 6 supervisory role, would she have been able to undertake this in the way she had? JMK stated it would have been much more difficult and staff would not have received the support that was needed. JMK explained that she was able to support both the nurse in charge of the ward & the nursing staff delivering patient care. RN stated that there was strong evidence around the developing supervisory role in driving quality and safety. RN asked what JMK felt could be taken from this experience into the Jersey Care Model (JCM) which will require staff to work differently. JMK responded that positive leadership, experience, and an enthusiasm to learn new skills. RN asked JMK how staff who had worked within one area for a long period of time adjusted and embraced this change, JMK responded that patient safety and patient experience was at the forefront of care delivery.<br><br>RR asked RN if the all Band 6 staff would transfer into a supervisory role. RN explained that this was being reviewed in all areas. It has not been possible in all areas due to staff vacancies and delivery of patient care comes first. RN explained that the requirements of a ward manager are significant and put simply, they run very complex businesses within a ward environment. In addition, there are key responsibilities in relation to quality and safety. Staffing reviews are underway within Community Services environments and this is one of the outcomes. One of the key priorities is that the ward managers are in a supervisory role which will drive the focus and commitment to the quality and safety agenda. RR asked if staff were enthusiastic in respect of this, RN responded yes although initially there had been mixed feelings. RR stated this was very encouraging for the future. RR asked if new staff / student nurses would be working across different areas as a new way of working, RN responded that those who train in Jersey work across two different areas with a view that they have a broader understanding and that in general staff are very flexible. RN highlighted that where staff feel anxious about working in different areas, this is usually driven by a concern that a mistake might be made; this is where the programme of training introduced and delivered by JMK and her colleagues addressed these fears and concerns. No-one wants to be in a position where they harm a patient. Providing that | |

| | | |
|---|---|---|
| | there is a good education and training package, good support, supervision, and role modelling by senior staff, this addresses those fears and anxieties. There is good learning for the JCM particularly those areas of care currently delivered in the hospital that can be delivered in the community / home setting and requires staff to work differently.<br><br>CL thanked JMK and the wider team and stated that this initiative demonstrated impressive work. JMK highlighted that all staff were involved and were keen to share their experience and knowledge with each other. RN also highlighted that JMK had received positive feedback from patients who have seen the changes in working practices, particularly patient specific pathways.<br><br>CL encouraged JMK to speak to AM to understand how the learning from this can be used in the future. AM stated that this was an excellent example of quality improvement and the feedback from JMK would be beneficial.<br><br>MWh stated that this experience should be shared with a wider audience, highlighting this as an example that all staff should be aware of.<br><br>RR thanked JMK for attending and delivering this experience, stating that it was encouraging and uplifting. JMK was thanked by the Board. | |
| **5.** | **Minutes of the previous meeting**<br>Pending some minor amendments, the minutes of the meeting 7 December 2020 were approved.<br><br>1. AN asked if under item 11 the wording could be changed from *higher intake* to *higher uptake.* This was agreed.<br>2. Trevor Pointon stated his title should be *Assistant Minister for Health and Social Services* not *Assistant Chief Minister.* This was agreed.<br>3. RR highlighted that his title and that of the Assistant Ministers is *(Assistant) Minister for Health and Social Services* not *Health and Community Services.* This was agreed. | |
| **6.** | **Matters Arising and Action Log**<br><br>No matters arising. | |
| **a.** | **M. Roach to provide more detail regarding zero-based savings for next year (2021).**<br><br>- MR advised that the budgets have been set and efficiencies have been applied. There is an ongoing review of the 5.2 million. There are some schemes in place. Working with AM and RS to identify the remainder, this will be monitored during the financial year. Any risks to achieving these efficiencies should be identified during the early part of 2021. RR asked if there is a report on how the savings are to be made, MR advised this is a work in progress and that the appropriate assurance committee will have oversight. **IT WAS RESOLVED** to close this action**.** | |
| **b.** | **R. Sainsbury and G. Caddell to meet regarding JHC and partnership discussion.**<br><br>- RS responded that this meeting had taken place. GC has been introduced to AM as the Executive link to HCS, particularly in terms of the JCM. GC also reported that she had met with BW from FNHC to discuss community nursing in general. A joint approach rather than an organisational approach was discussed. RN advised that G. White has recently met with GC. CL keen to ensure that RN has a line of sight to this. RN and GC will discuss this further outside of this meeting. **IT WAS RESOLVED** to close this action and the appropriate assurance committee will maintain oversight of this. | |

| | | |
|---|---|---|
| **c.** | **CL will request a review of SALT**<br><br>- EOC advised that this review had taken place and a paper had been produced by S. McManus (Therapies Lead). Unfortunately, neither C. Power (Head of Allied Health Professional) or S. McManus could attend the meeting today to present this work. S. McManus has confirmed availability for 8 March 2021. EOC suggested that this is deferred to 8 March 2021 if acceptable to the Board. RR in agreement & asked if the paper could be circulated to Board members. **IT WAS RESOLVED** to carry this action forward. | |
| **d.** | **SL to link in with FNHC and provide support re: TEAMS.**<br><br>- SL explained that he has been working with J. Foglia to understand the issues. FNHC have been working with Modernisation and Digital for a number of months. This is a complex licensing issue. SL has been assured by (MD) that working to try and resolve. However, part of this is a commercial decision is required from FNHC. SL confirmed that FNHC can use non-GOJ devices to join calls / meetings (including Board) and SL has advised FNHC of this. EOC advised that FNHC continue to receive all the Board papers & if in a similar position in March, EOC will arrange for an appropriate environment at which BW can join EOC to participate. **IT WAS RESOLVED** to carry this forward for a further update at the next meeting. | |
| **e.** | **NDJ / AN to liaise to facilitate delivering service-user story to the junior doctors.**<br><br>- AN advised that SV has agreed to participate in the doctors teaching. This will be Sept / Oct 2021. **IT WAS RESOLVED** to close this action. | |
| **f.** | **Director Modernisation to provide CEO FNHC with a map of current HCS workstreams.**<br><br>- EOC explained this was a historical action. CL asked if AM could nominate a member of her team to follow this action up. **IT WAS RESOLVED** to carry this action forward. | |
| **g.** | **Deputy Director of Primary & Community Pathways to progress work in relation to the recovery and provision of support to the 65+ population in isolation to give them confidence to reengage with others.**<br><br>- RN advised that this resulted from the Public Health (PH) shielding strategy. This action has now been superseded. Work ongoing through PH and partner organisations. RS advised that the PH team are doing an impact assessment of PH measures through Covid and this will include loneliness / communities and how individuals have remined connected / disconnected. This will be used to inform future decisions within PH. **IT WAS RESOLVED** to close this action. | |
| **7.** | **Chair's Report**<br><br>In reference to the number of Covid infections, RR advised that the Island is in a different place now compared to when the Board last met in December 2020. This is due to Islanders observing the guidance, keeping themselves and others safe; continued caution is required. There is a strategy for relaxing the restrictions which is important for health and wellbeing and the economy. This is a difficult situation to manage but there are excellent teams in place.<br><br>Our Hospital project is making steps forward. The Overdale site has been approved as the preferred site but there has been resistance in relation to access to the site (rather than the site itself). GOJ has been advised by experts that access does need to be improved and Westmount Road is the best of all available options. The project will progress to the planning stage and members of the public and States Members | |

| | | |
|---|---|---|
| | can put forward their views and if valid, the planning inspector will take these into account.<br><br>The functional brief for the Our Hospital project has been published which is a detailed analysis of the services that will be provided both in the Hospital and Community settings.<br><br>RR advised the Board that Patrick Armstrong has been appointed as Group Medical Director for Health and Community Services and congratulations given. RR looking forward to working with PA in the future: his guidance, integrity, and hard work. Acknowledging that PA is not only continuing to work clinically but also contributing significantly to the Public Health needs of the Island as the Chair of Scientific and Technical Advisory Cell (STAC).<br><br>RR advised that the progress of the vaccination programme is uplifting. RR visited Fort Regent prior to opening which is an excellent facility operated by an equally excellent team. RR stated that he received correspondence at least daily with positive feedback in relation to this. This has given Islanders confidence that this can be managed well in the future. | |
| **8.** | **Director General's Report**<br><br>CL echoed RR comments in relation to the Our Hospital project.<br><br>HCS continuing to work closely with the Jersey Care Commission (JCC) who are currently registering some HCS facilities; this is being led by the Chief Nurse.<br><br>JCM work continues at pace and this is being driven by AM's team working with partner organisations.<br><br>There are no Covid positive patients in the hospital currently. Elective work continues at pace and has continued for urgent / cancer patients throughout the pandemic. RS and the wider team have done excellent work manging the elective waiting lists although pressure points do exist, particularly mental health.<br><br>CL thanked all HCS staff for all their continued work and partnering organisations for the collaborative working that has taken place during these difficult times. | |
| **9.** | **<u>View from the Bridge (Partner Organisations)</u>**<br><br><u>Jersey Alzheimer's Association</u><br>Apologies given. CL advised that a new CEO has been appointed as S. Pontin is leaving. SP has requested that the incoming CEO joins Board on 8 March 2021. RR thanked SP for all his efforts on the HCS Board.<br><br><u>Brighter Futures</u><br>RB reported an increased demand for the services of Brighter Futures, highlighting a 58% increase in current case load of pregnancies, new babies, and babies under 12 months of age (before the end of March). Also anticipating more referrals as the year progresses and because of lockdown.<br><br>Support is being increased for parents and babies and offering more groups for babies under the age of 1yr to look at secure attachment and mental health and wellbeing. Working in partnership on the development of perinatal pathways. Also prioritising mental health and wellbeing as this is a significant issue. The range of services offered to parents and carers has increased and to children of school age (within current case load) through drawing and talking.<br><br>Working in partnership with Art House Jersey which is in the very early stages. This is a pilot project with an artist in residence which may be an art project with parents and children or journaling with mothers. This is a therapeutic approach. | |

In relation to the voluntary and community sector, the children's cluster met last week. The items most relevant to Board are,

- The apparent lack of a cohesive and coordinated recovery plan for children and families. There are discreet areas that are being addressed but this has not been joined up. It was agreed at this meeting that this will be raised at the Children and Young People Strategic Board.
- It was also noted that for a variety of reasons, the Children and Young People Strategic Board has not met for a while and this will be raised directly with the Chair.

RB also advised that BF is working to produce video training on outcome-based accountability. AM advised she was aware of this work and hoping to become more involved from a commissioning perspective, and how this can be used across all partners. RB highlighted that this would give those who provide funding the detail as to what difference is being made to others.

RN thanked RB for the update. In relation to the 58% increase in referrals of those under 1yr & new mothers, RN asked what the relationship is between these referrals and any unmet need through health visiting services during covid; is there a direct connection? RB advised that these are not new referrals but current caseload. RB explained that BF is working closely with health visitors as this is the largest source of referrals, acknowledging that FNHC are experiencing capacity issues.

RR advised the Board of the work that RB is doing with the Council of Ministers due to the recognition that throughout last year, babies have been born and are growing up with very limited contact with people. These children may be developing in a different way and this must be addressed to ensure these children are not harmed.

RR will take the issue forward in relation to the Children and Young People Strategic Board not meeting. RB advised that a coordinated approach is required around how to catch up and the remedial work with children and families. The New Perspectives report (Dec 2020) around economic recovery was well coordinated and highlights that the same approach is required for children and families across the Island.

<u>Jersey Hospice Care (JHC)</u>
GC advised that JHC has remained busy. Within the inpatient unit, there appears to be a trend of late presentation / diagnosis of end of life care. The complexity around these patients and their families is increased due to the shortened timeframe between diagnosis and death. This has had an emotional impact upon staff, further exacerbated by visiting restrictions. Working to ensure a support system is in place for staff; a huddle takes place every shift, regular reflections, and one-to-one and group supervision. However, staff are tired.

A Clinical Fellow joined last August who has experience in Palliative Medicine and will continue to support until August 2021. GC has met with Dr E Liakopoulou & spoken with J. Mason: going out to recruitment for a Consultant / Associate Specialist (AS), depending upon applicants. A contract has been agreed with Southampton NHS for off-island Consultant advice. Verbal agreement with the Lead Consultant in Southampton that if an Associate Specialist is recruited, a professional development pathway will be agreed for the AS with time over in Southampton to work towards becoming a Consultant.

Community provision: there is a six-day face-to-face service with the remaining day as telephone consultation only. This is due to capacity. Workforce is a challenge especially recruitment off-island. An increase in referrals over the last couple of weeks has been noted, particularly patients declining to seek both primary and secondary medical care support with symptoms due to Covid. All this data is being captured with a plan to produce a paper in the future.

Day services remain suspended and the workforce has been redeployed. GC has met the Head of the JCC to discuss what could be done in terms of reopening day services and how this could be done safely. Also working with MacMillan and have a complimentary therapy service in place; this is a joint post that has been recruited to. Meeting Jo Poynter and Washington Gwatzido in relation to lymphoedema services, specifically a whole island provision.

The JCC report has been received recently and the feedback is positive. When JNAAS was launched, G. White approached GC and asked if this assurance mechanism was a tool that JHC may be interested in implementing. This was viewed as an excellent way to engage staff. The implementation of JNAAS was favourably mentioned by the JCC within the report.

There has been no Covid within JHC. Peer-to-peer swabbing monthly. A senior nurse from JHC had been seconded to the vaccination programme for a month & enjoyed the experience.

GC highlighted the excellent support received from Infection Prevention and Control (IPAC). GC noted the credibility of the staff who always answered any queries. RN advised that this would be passed on to the IPAC team. There is always JHC attendance at the Community bronze team meetings.

GC advised that the CEO recruitment is underway following the resignation of Emelita Robbins late last year. The advert will be released shortly.

RR asked about the MacMillan complimentary therapy service and what did this consist of? GC explained this is a jointly funded post; patients are under the care of MacMillan in the morning and JHC in the afternoon. This operates out of the Lido Centre. GC highlighted this is an example of working differently.

<u>Family Nursing and Home Care (FNHC)</u>
Apologies given.

<u>MIND</u>
PT advised that an increase had been noted in people asking for help, approximately 50% especially to the call line. PT stated this increase made sense due to the hard work from MIND & partner organisations to raise awareness of the services. This increase is viewed as positive as people are seeking help, particularly from carers or with peer support.

There has been interest in developing the peer support services and individuals have been volunteering. One of the key priorities for MIND has been to extend the peer support service as currently the service exists to support those between ages of 25-65, whereby those with lived experience go on to support others. Working hard over the last few months to develop this service across both the perinatal sector and those over the age of 65 who have ongoing enduring mental health problems.

Two individuals have been recently recruited to the pilot project. These will be working with colleagues around the table, Brighter Futures, Recovery College, Midwives and Health Visitors to ensure that people are made aware of this service and can seek support from people with lived experience. A key message is that this works alongside rather than replaces clinical input. There is a plethora of research to demonstrate this works and it is part of the MIND Mental Health Improvement Plan & recovery plan. PT advised Board members that she can be contacted for further details in relation to this.

As part of the raising awareness campaign, there has been a lot of response to the peer support. As an example, PT relayed some feedback, *we are really pleased to hear that the message is getting out there that professionals do not own services, they need to be designed and co-produced with the people who use them because this is what will make the difference between good and great services.* PT stated that her

| | | |
|---|---|---|
| | understanding of peer support and co-production has changed and developed, advising that this is an area to be embraced and approach differently as part of recovery plans.<br><br>An overall part of the strategic plan is to increase access to services generally. This is driven by a reluctance of people to seek help. One of the strategic pieces of work at present is to develop a strategic advisory panel consisting of people from minority ethnic groups who will work with all partners. This panel will be helping to identify gaps and develop an understanding as to why people from minority groups are not accessing support.<br><br>A pilot project has been started with CAMHS. MIND has agreed to work with 10-15 young people and following this will review and evaluate what difference this has made.<br><br>Recent conversations with IW (Associate Managing Director MHS & ASC) in relation to Camelot. These are early conversations to look at what can collectively be done for those living with long term enduring mental illness to have better outcomes and live a better life.<br><br>The residential care well being Wednesday offer was accepted by six care homes. This enabled conversations with those who were unable to have visitors. PT advised this was a remarkable experience. This is a pilot project but following this a link has been made with a music charity. This provides further opportunity to work differently so that those confined can access music through technology.<br><br>RR thanked PT for the summary of activity taking place within MIND. RR highlighted that MIND is a key partner and fundamental to safeguarding the mental health and wellbeing of Islanders. RR thanked PT's wider team.<br><br><u>General Practice</u><br>Apologies given.<br><br>AM commented that the partner updates are very useful, providing an overview of the activity and challenges experienced across the health system. | |
| **10.** | **Performance Report**<br>AC guided the Board through the Performance report Dec 202 / Jan 2021 highlighting the following points,<br><br>• Over 2020 a decrease noted in activity across a number of services (both emergency and elective).<br>• An increase in activity is noted through Jan 2021, not to previous levels but an increase none the less.<br>• An increase is noted in elective activity and day cases.<br>• This activity portfolio shows the long decreases and fluctuating activity during 2020 but now beginning to see an upturn in 2021.<br>• The outpatient and inpatient waiting lists have been impacted during 2020. However, there is a large amount of detailed work continuing to recover from position. A peak noted in October / November 2020 with over 10,000 patients. This is now under 10,000 and continuing to decline.<br>• Some specialities have been impacted more than others during Covid. Activity has been maintained as best as possible through either face-to-face or telephone consultations but this challenging for some specialities. For example, physiotherapy / musculoskeletal / trauma and orthopaedics and general surgery is very difficult to assess over the telephone and these are the areas where an increase in the Patient Tracking List (PTL) is noted.<br>• In comparison, the paediatric PTL has decreased by 150 cases.<br>• For the same period last year, dermatology was at 505 patients waiting, this is now at 596, peaking at 796 during December 2020. A locum is in place to facilitate this recovery. | |

| | | |
|---|---|---|
| | • Despite all the Covid disruption, the surgical PTL has decreased by 165 patients. This is an achievement. General surgery has been particularly successful following the implementation of a new timetable during the summer.<br>• There is an increase in the Ophthalmology out-patient PTL and a lot of this is converting across to the in-patient PTL. As the OPD PTL decreases, a consequential increase in the elective PTL may be noted.<br>• Endoscopy has been an area of concern. However, a third Gastroenterologist will be starting shortly.<br>• The community mental health caseload has remained stable through Covid but the CAMHS caseload continues to increase. The Jersey Talking Therapies referrals are also staring to increase.<br>• The maternity data is demonstrating the positive work of the Maternity Task and Finish and this continues to be monitored.<br>• Outpatient work is increasing. The Did Not Attend (DNA) rate is recovering and the new-to-follow up ratio has decreased to pre-covid levels.<br>• The emergency length of stay has increased but this is due to the nature of patients presenting.<br>• The Emergency Department (ED) activity is increasing. The quality indicators (time to triage, time to being seen) benchmark well against the NHS. The conversion rate has increased which is expected at this time of year, but it is higher than last winter. This is most likely due to the nature of patient presentation during Covid.<br>• A decrease in the number of patients being discharged by midday noted during Jan 2021. This is an area that the operational team will explore.<br>• The occupancy within the mental health locations is very high, almost 100%, within the in-patient wards.<br>• The Jersey Talking Therapies (JTT) waiting lists have recovered very well. In January 2020, 621 patients outstanding. This has reduced to 76 outstanding January 2021. Over 76% of those in January 2020 were waiting 18 weeks or longer, this has decreased to 26% January 2021. Those waiting for first treatment is 106 in January 2021 compared to 655 Jan 2020. This highlights the good work that has been undertaken within this service.<br><br>RR thanked AC for the comprehensive report and the rigor that is applied to the performance data. RR asked if the mental health data would be included on the public website. There have been some challenges extracting the data electronically as different systems are used but a system has been developed and is in the very early stages. RR advised that this was good news and looks forward to seeing the progress in this regard.<br><br>In relation to the mental health indicators, RS advised that work is still required around the new services that have been established, particularly the crisis prevention service and the home treatment team. This team has taken a proportion of what would have been community caseload. There has been success from this team in preventing admission and supporting discharges form Orchard House. Work continues in this area as this is a large part of the JCM ambition.<br><br>RS echoed AC comments around the high level of bed occupancy within the mental health in-patient unit.<br><br>In relation to length of stay, the normal discharging of complex care patients with the domiciliary care market has been impacted through wave 2. Beginning to note a recovery but there is still a long way to go.<br><br>In terms of the mental health dashboard, PT advised that MIND Jersey keen to be involved in any conversations especially around the peer support offer. Conversations have started with the home treatment team. RS thanked PT and stated this would be very useful in the future. | |
| **11.** | **Committee Report – Quality Performance and Risk**<br>RN took the paper as read and highlighted some points from the Committee, | |

| | | |
|---|---|---|
| | • The Maternity Task and Finish work continues and progressing at pace. A significant amount of work has been undertaken this year. Scrutiny panel has announced a review of maternity services and this will be reported through HCS Board in due course.<br>• Regulation of Care: There are 17 areas within this remit, 12 of which are now fully registered. This is two home care areas, six care homes and four day care services. Within the remaining areas there are some challenges, particularly in relation to the physical environment. Work is continuing with the JCC in this regard.<br>• Clinical Governance arrangements: The care group performance reviews have recommenced, and it is evident that all care groups are managing their clinical governance arrangements. This was also demonstrated in the Quarter 4 Datix report where incidents are being investigated within specified timeframes.<br>• Mental health services: Significant work continues within mental health services particularly JTT referrals times and the reduction in the waiting list for Tier 2 services. The services are continuing to improve despite the demand that is being placed upon them at this time.<br><br>RN invited questions. In relation to the increased length of stay from 4-5 days to 7.1 days, RR asked how is this accounted for? RS responded that this is related to the availability of packages of care and the domiciliary care market. There is pressure in this part of the system, and it has been exacerbated by Covid. Acuity will also be a factor, more complexity of patients admitted. AN advised at this time of year, would expect to see more patients with complex comorbidities in the ED. AN advised he would expect to see this position improve as we move into Spring. | |
| **12.** | **Committee Report – People and Organisational Development**<br>NC (deputising for SG) took the report as read and highlighted some of the main points,<br><br>• The DBS update is progressing due to partnership working with colleagues across GOJ.<br>• Working with C. Power (Wellbeing Lead) to develop a women's health day in March 2021.<br>• The strategic workforce planning is progressing, and a further meeting is due with maternity.<br>• In terms of recruitment, individuals are actively contacting HCS enquiring about nursing vacancies. These individuals are from a range of nursing backgrounds including Drugs and Alcohol.<br><br>RN appraised the Board that the Advanced Clinical Practice Framework and job description were approved at the last meeting of the POD Committee. This has been developed across partner agencies with the intent that this becomes the model of advanced clinical practice in Jersey. There is one framework and job description for nursing, AHP's, midwives which follows both National and International practice. RN would like to see this paper reviewed at Board as the intention is to adopt this Island-wide. | |
| **13.** | **Financial Report**<br>MR took the report as read and highlighted the following points,<br><br>• The figures presented are pre-audit and have not been confirmed. However, not anticipating any material changes to this position.<br>• HCS 65K underspent against a budget of 250million for 2020. Given the volatility around the year end, this is a significant achievement.<br>• Moving forward work will be done towards the 5.2 million and the recurrent 9 million savings that was paused last year due to Covid. This needs to be achieved in addition to the 5.2 million and the plans for this will be worked on throughout the financial year.<br>• The forecast for the next report will based on month 2 (February 2021) and presented at the meeting of the Board in March 2021. | |

| | | |
|---|---|---|
| | HR asked RR what happens to the underspend. RR and MR confirmed that this money is not rolled over to 2021.<br><br>RR advised that Treasury have been supportive of the Covid response. The needs of the Island through the response to Covid has been funded. RR expressed his gratitude for this as Minister for Health and Social Services.<br><br>HR asked if there was clear indication of the number of individuals that are not attending appointments as there is a cost attached to this. AC confirmed the DNA rate for Jan 2021 is 6.2%. HR advised that he had received a comment in relation to this and it was unfortunate that this is not communicated to those who do not attend. CL in agreement and stated that some NHS organisations have led successful campaigns to address this and this is an area for further consideration following the pandemic. AC advised that the point about missed appointments is communicated with the public waiting list data i.e. how many there are, what people can do if they cannot attend an appointment. MR feels that the loss to HCS and GOJ is worth quantifying. | |
| **14.** | **HCS Board Assurance Committee Restructure**<br>EOC took the paper as read and advised that seeking approval for the restructure of the Assurance Committees constituted by the Board.<br><br>• Quality, Performance and Risk Committee will be come the *Quality and Risk Committee.*<br>• The Finance and Modernisation Committee will become the *Operations, Performance and Finance Committee.*<br>• The assurance committees will meet according to a 5-weekly cycle.<br><br>Approval was given by the Board. RR expressed concerns that the 3-weekly cycle of States meetings could impact upon the Board timetable and rather than cancel any meetings, seek alternatives for the Chair at this time.<br><br>EOC explained that the Terms of reference (TOR) for the Board and assurance Committees was due for review and any changes would be presented to the Board.<br><br>For clarity, CL explained that this is an iterative process and the current position may differ as the year progresses. However, the current structure is more responsive to the governance needs of HCS at this time. | |
| **15.** | **Any Other Business**<br>HR highlighted that he has never received so many compliments as he has done in relation to the vaccination programme. HR asked for this to be noted, particularly the team working during the recent cold weather. AN thanked HR for this comment. AN echoed the fantastic work and the achievement of delivering over 20,000 vaccines. 97% of individuals over the age of 80yrs have received the Covid vaccine, this is 20% of the mortality rate. AN stated that these individuals have a much higher chance of surviving Covid if contracted and there are very few things in medicine that have this type of an impact upon a Community. 82% of care home workers are now vaccinated, at most 60% of care home workers are vaccinated in the UK. AN feels that it is important that the whole community celebrates this success.<br><br>RR would like to formally record thanks from himself, Trevor Pointon and Hugh Raymond to all who are involved in the delivery of the vaccination programme.<br><br>RR advised HR that he send any compliments to B. Sherrington and advised that he can forward on HR's behalf.<br><br>RR thanked all for attending and closed the meeting. | |
| | **Date of Next Meeting**<br><br>The next meeting takes place on 8 March 2021 | |

# Professional story

Redeployment within surgery

February 2021

Sister Jenna Mackay

# How & why it started …

- Elective surgery to recommence in July 2020
- Beauport ward became the emergency surgical admission ward for both male / female general surgery & orthopaedic
- Rayner & Portelet became elective surgical wards (Rayner for orthopaedic & gynae & Portelet for all other general surgery)
- Redeployment was essential to ensure safe patient care was delivered and standards were maintained during this process
- Rayner ward manager & Beauport ward manager swapped wards initially for a 2–4 week period to assist with upskilling workforce within the specific area. This ended up being 3 months, July – October
- Initially five staff between the three wards were redeployed to assist with skill mix. After the first month it was identified more staff were required to ensure a safe delivery of care. Eight staff were then redeployed.

# Support & Training …

What we did as managers:

- Myself & Beauport Ward Manager facilitated twice weekly training in the Halliwell lecture theatre with a weekly topic
- Actively encouraged ad hoc training on the ward during any ‘downtime’
- Encouraged senior surgical & gynaecology registrars / middle grades to assist with teaching
- In a supervisory role, worked closely with staff delivering patient care – identified obstacles to the provision of timely and high quality patient care
- Educational resource folders / boxes made for each ward (Gynaecology, bowel obstruction, orthopaedic) by the link nurses on each ward.
- Educational boards on each ward developed

# Sharing of ideas, changes made …

Changes were made to adapt to an emergency surgical ward including:

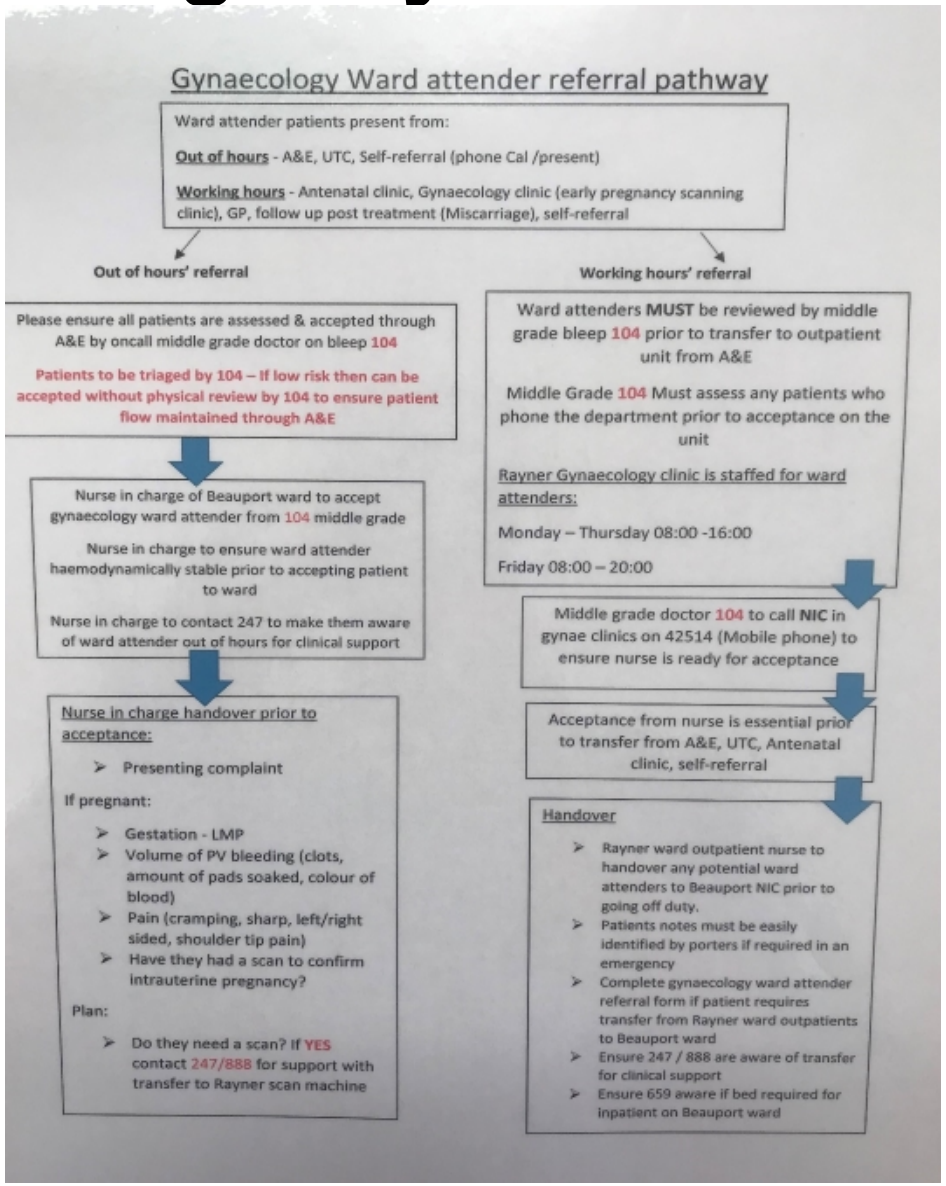
- Ensured safety huddle was mandatory x3 daily with on ward surgical FY1's in attendance to ensure MDT approach to patient safety
- Implementation of emergency boxes in each bay 'grab boxes'
- Essential storage trolleys outside each bay with surgical equipment for ward rounds / bleeding wound etc.
- Re-organised store room and ordering system to ensure surgical supplies were available
- Re-assessed pyxis stock to mirror an emergency surgical ward

# Changes to gynaecology emergency ward attenders …

Rayner ward attenders pathway had to be revisited due to covid.

Changes made:

- Staffed gynaecology clinics including ward attenders separately from the ward for the three month period to ensure the service was safely staffed
- Ward attender set clinics devised Monday, Wednesday & Friday to reduce the amount of OOH referrals, drop ins from ward attender patients who are predominantly pregnancy related
- Gynae. ward attender referral pathway devised)
- Formal gynae. nurse handover devised for staff to ensure communication not lost in transit



# Positives from redeployment

- Patient safety maintained
- Professional achievement
- Awareness of own resilience, self – control, determination and other personal qualities
- Shared experiences, knowledge & skills
- Broaden skill set of nursing teams
- Built working relationships between teams
- Staff in gynae. clinics have worked much more autonomously and are excited about future development within the service

# Barriers overcome …

- Managing & leading a new team with little to no knowledge of the team
- Initially reinforcing a positive mind-set – now all staff are very positive about the change
- Encouraging a ‘can do’ attitude
- Managing a varied amount of staff expectations and resilience levels within the team with limited knowledge of their background
- Managing performance & competencies reviews

## HEALTH AND COMMUNITY SERVICES BOARD - ACTION TRACKER

| Meeting Date | Agenda Item | Action | Officer | Exec | By When | Progress report | Action Agreed | Action Closed Date | Status |
|---|---|---|---|---|---|---|---|---|---|
| **12-Oct-20** | **9** | CL will request a review of SALT | C. Landon | | | Update 15 Feb 2021<br>Review has taken place. Therapies Lead will attend on 8 March to summarise. EOC to distribute paper.<br><br>Update 7 Dec 2020<br>CL asked RN to action this. CL asked GW to link in with therapies re: SALT review. | | | **OPEN** |
| **12-Oct-20** | **9** | SL to link in with FNHC & provide support re: TEAMS | S. Lempriere | | | Update 15 Feb 2021<br>See minutes. RR requested a further update 8 March 2021. | | | **OPEN** |
| **14-Sep-20** | **10a.** | Director Modernisation to provide CEO FNHC with map of current HCS workstreams. | J. Poynter | A. Muller | | Update 15 Feb 2021<br>CL advised that a member of Innovation & Improvement Team discuss this with FNHC<br><br>Update 7 Dec 2020<br>EOC will contact BW to confirm whether this has happened.<br><br>Update 12 Oct 2020<br>In BW absence IT WAS RESOLVED that CL would carry this action forward & discuss with BW next week. | | | **OPEN** |

# QUALITY, PERFORMANCE AND RISK COMMITTEE REPORT

| Author(s) and Sponsor | |
|---|---|
| Author(s): | Rose Naylor Chief Nurse |
| Sponsor: | Deputy Trevor Pointon |
| Date: | 8th March 2021 |

## Executive Summary

### Purpose

The purpose of this paper is to provide the HCS Board with an update on the matters considered by the Quality, Performance and Risk Committee in the meeting which has taken place since the HCS Board last met. The date of this meeting was 17th February 2021.

### Narrative

This Committee covers the combined agendas of two previous Committees, the Quality and Performance Committee and the Risk and Audit Committee.

At HCS Board on 15th February a revised Committee structure was presented and approved. The Terms of Reference and scope of this Committee in light of this approval is now Quality and Risk Assurance – Performance as an agenda item has moved in the Operations, Performance and Finance Committee.

### Performance Report

Operational performance will now be presented and discussed at the Operations, Performance and Finance Committee. First meeting under the revised Terms of Reference to take place on 25th February.

### Regulation of Care Monthly update report.

Update on the progress towards registration of a number of care areas predominately within the community services portfolio of Learning Disability and Mental Health Services with 12 areas now fully registered. Challenges remain in two sites relating to the registration and physical environment, continuing to work with the JCC on these issues and each area of service has a full plan of work and timeline.

### Risk Register monthly report.

Update on the HCS risk register. Risk evaluation is part of the monthly Care Group Performance Reviews and there is also oversight of risk at the other relevant Assurance Committees. For example, People Organisation and Development Assurance Committee will have oversight of the relevant workforce risks.

The report considered all risks currently sitting on HCS risk register assessed as scoring 15 and above. The Committee were assured on,

- new risks added since the last meeting
- risks reviewed and re-rated at a lower rating due to mitigation
- those risks remaining the same following review.

Papers from the Care Group Performance reviews which will now come to the Committee include detail on risks within each care group reviewed as part of their Care Group Governance arrangements.

### Infection prevention and control monthly report.

Key areas covered included:

- COVID activity in month

- Audit reports - equipment, PPE, hand hygiene, outbreaks, environmental
- Risks

Complaints performance Quarterly Report – Q4 2020

Update on Feedback activity during Q4 2020 – with a specific focus on complaints performance, which is showing an improving picture, specific focus on complaints performance and learning from complaints happens within the Care Group Performance Reviews.

Safeguarding Designated leads Quarterly Report – Q4 2020

This report focussed on safeguarding activity across the health system and provided an overview of safeguarding activity across a range of services during the second wave of COVID. The report reflected the positive working across a range of services and partner agencies to safeguard the most vulnerable in our community, of particular note has been the wider societal impact of the pandemic particularly on islander's mental health.

Serious Incidents Quarterly Report – Q4 2020

Report provided for assurance and information on activity. The position at the end 2020 had improved with a number of reports completed and lessons learned.

Service Improvement – Maternity & Task Finish Group monthly report

Update provided to give assurance of the pace and focus of the work in Maternity, the group continues to meet monthly with the Executive Tri.

The Committee were informed of the Health and Social Security Scrutiny Panel's Review of Maternity Services.

An update was provided on the progress on the Maternity Voices Partnership Forum.

The Maternity Service has achieved Accreditation at Level 1 of the UNICEF Baby Friendly Initiative .

Mental Health inpatients tracking list (PTL) Trajectory

Update provided, some services have this such as Jersey Talking Therapies however there remains a challenge with the interface of systems, and so this remains work in progress and will continue to be monitored by the Committee.

Committee Report (for information)

Research Ethics Committee Annual Report 2020 received.

Committee Report (for information)

Medicines Governance Committee - Summary and overview and copies of minutes received.

Care Group Performance Reviews

Information received from the Care Group Performance Reviews for information and assurance, with a focus on the Medical Care Group at this Committee. In future all Care Group Performance review documentation will be shared with the Committee for information, and assurance.

Key Issues to Note – no matters identified at the February QPR to be escalated to Public Board

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| The Board is asked to **NOTE** the Report | | | | | | | |
| **Impact upon Strategic Objectives** | | | | | | | |
| The strategic objectives for HCS are to be determined | | | | | | | |
| **Impact Upon Corporate Risks** | | | | | | | |
| None to note in this report | | | | | | | |
| **Regulatory and/or Legal Implications** | | | | | | | |
| There are no specific regulatory or legal implications arising from this report. | | | | | | | |
| **Equality and Patient Impact** | | | | | | | |
| There is no equality or patient impact arising from this report. | | | | | | | |
| **Resource Implications** | | | | | | | |
| Finance | | Human Resources | | IM&T | | Estates | |
| **Action / Decision Required** | | | | | | | |
| For Decision | | For Assurance | √ | For Approval | | For Information | |
| **Date the paper was presented to previous Committees** | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| **Outcome of discussion when presented to previous Committees/MEx** | | | | | | | |
| | | | | | | | |

| Report Title |
|---|
| COMMITTEE REPORT<br>Finance, Operations and Performance Committee |

| Author(s) and Sponsor | |
|---|---|
| Author(s): | Dr Anuschka Muller, Director of Improvement and Innovation |
| Sponsor: | Caroline Landon, Director General |
| Date: | 01 March 2021 |

## Executive Summary

### Purpose

To provide a summary of the last Finance, Operations and Performance Committee (FOPC) meeting, to highlight good practice examples and issues for escalation to the Board.

### Narrative

The FOPC met for its inaugural meeting on 25 February 2021. Extremely well attended by all Members, and the Minister listened in. Overall feedback of the meeting has been positive with suggestions made for future improvements to ensure the committee contributes effectively to the overall governance.
Key items to note:

- The ToR were presented and discussed. They will be presented again at the next meeting once comments have been incorporated.
- The HCS Performance Report has been improved and included an excellent in-depth presentation of Adult Mental Health performance metrics which encouraged a wider discussion amongst members. Actions were taken to bring the issues identified to a wider audience, including STAC, Public Health and Children and Young People Services to support the strategic prevention planning.
- The PTL report showed progress made in understanding the waiting lists and the position after the Covid-19 waves in spring and December 2020. Further work is currently underway to improve understanding and reporting of patient groups, waiting times for patients and the trajectory of the reduction of waiting lists and will inform Care Group Performance Review meetings and this committee.
- Reports from the Care Group Performance Review meetings provided good assurance on process and systems in place to drive effective and efficient service delivery. Issues on template content and further standardisation to avoid duplication of work were highlighted and actions taken to solve these for future meetings. Strategic discussion in future committee meetings to be encouraged by presentation of key highlights from each group.
- Good assurance was provided on the review and updated operational and clinical hub process highlighting key areas of learning and improvement. Discharge challenges and increased lengths of stay for medically fit patients over the last months were mainly attributed to a lack of capacity in the domiciliary care market.
- Challenges in resource management are experienced by HCS services due to the limited capacity and limited access to systems from People Services and Treasury. This is being discussed with the corporate services teams.
- The Governance Framework and the ToRs for the Jersey Care Model Programme were noted and signed off by the committee.
- A new strategic planning and reporting framework is currently being implemented by HCS and an overview has been presented of its components. This is a key element of good business and resource management and has been noted by the Chair as positive progress.
- In its reflection of the meeting the committee agreed to include a patient/staff story at each future meeting to align with the Quality & Safety Strategy.

## Recommendations

The Board is asked to **NOTE** the Report

| Impact upon Strategic Objectives | | | | | | | |
|---|---|---|---|---|---|---|---|
| The FOPC is an important part of the overall HCS Governance and contributes therefore positively to the strategic objective “High quality safe services with good clinical and corporate governance functions”. | | | | | | | |
| **Impact Upon Corporate Risks** | | | | | | | |
| n/a | | | | | | | |
| **Regulatory and/or Legal Implications** | | | | | | | |
| n/a | | | | | | | |
| **Equality and Patient Impact** | | | | | | | |
| In line with the Quality & Safety Strategy, a patient/staff story will be presented at each meeting to increase awareness and share lessons learnt. | | | | | | | |
| **Resource Implications** | | | | | | | |
| Finance | | Human Resources | | IM&T | | Estates | |
| **Action / Decision Required** | | | | | | | |
| For Decision | | For Assurance | √ | For Approval | | For Information | |

| Date the paper was presented to previous Committees | | | | |
|---|---|---|---|---|
| n/a | | | | |
| | | | | |
| **Outcome of discussion when presented to previous Committees** | | | | |
| n/a | | | | |

Health and Community Services

# Committee Report

## Exemption: Policy under development

| | |
|---|---|
| **Guidance on completing this report** | • Complete all parts of the report template<br>• Ensure issues are described succinctly<br>• Limit the report to no more than 3 pages<br>• Attach any additional relevant information as appendices<br>• All reports to be provided 5 working days before the meeting |

| | |
|---|---|
| **Report to:** | HCS Board |
| **Date of meeting:** | 8 March 2021 |
| **Title of paper:** | Jersey Care Model Governance |
| **Report author:** | Stephen Bull – Programme Manager |

### 1. Purpose

| | |
|---|---|
| What is the purpose of this report? | To seek approval for the governance framework in order to progress with establishing governance over the delivery phase of the JCM.<br><br>The framework also covers governance of the wider HCS change portfolio. |
| What is being asked/recommended to do/decide? | To approve the governance framework proposed. |

### 2. Background

| | |
|---|---|
| Why is this matter being brought? | The JCM was approved by the States Assembly in 2020 through P114.2020 and the Government Plan 2021-24.<br><br>In order to ensure the next phase of the programme is successful and that stakeholder engagement and design quality is high, an externally facing support structure is required, which facilitates system working, partnerships, and advice and guidance from a mix of professionals and service users.<br><br>Through the JCM approval process via P114.2020, the Minister also committed to establishing an external independent assurance board to oversee progress of the care model delivery programme. The new governance structure for the JCM will interact with the HCS governance processes and so approval to proceed is required from the existing governance arrangements.<br><br>In terms of development of this framework, these are the steps taken, with incorporation of recommendations at each stage: |

| | |
|---|---|
| | • Development of outline with PCB (GP's) – started in Nov 2020<br>• Public consultation with external and internal stakeholders (Nov/Dev 2020)<br>• Review with MSC (Medical Staff Committee)<br>• Review with Scrutiny and Minister (Dec-Jan)<br>• HCS SLT review (Jan 21)<br>• Review with GoJ CEO (Jan 21)<br>• Legal review (Feb 21) |
| Which assurance committee[i] or subordinate committee has this been to and were there comments / recommendations to consider? | The governance framework will go through the following approval route:<br><br>HCS Senior Leadership Team: 18 Feb 2021 (approved)<br>Minister for Health and Social Services: 19 Feb 2021 (approved)<br>Operations, Performance & Finance Assurance Committee: 25 Feb 2020 (approved)<br>HCS Board: 8 March 2021<br><br>Note that the framework has also had external, Scrutiny and legal review in its development. |

## 3. Key Issues

| | |
|---|---|
| What are the key issues to be aware of? | To oversee and inform the delivery of the JCM, an appropriate governance structure is required. Terms of reference for each group have been included.<br><br>The proposed groups have no financial fund allocation authority and cannot commit the Minister to expenditure or change health and care policy.<br><br>The establishment of the Independent Oversight Board (IOB) has been agreed by the States Assembly as part of the amended proposition P.114/2020. The IOB's function is to agree the provision of regular assurance reports to the Minister and Scrutiny panel. This could bring additional scrutiny of HCS processes.<br><br>A system wide health and care partnership group is proposed. The group aims are to increase the health and wellbeing outcomes for Islanders by increasing collaboration and integration between all stakeholders and providing a platform where opportunities to join up health and care are well communicated and shared.<br><br>Two advisory functions will be established to inform the design of pathways and services, both will involve wide engagement outside of HCS. Neither are statutory or budget holding groups.<br><br>• Clinical Professional Advisory Forum<br>• User Experience Panel<br><br>Support for the JCM Governance framework and its groups will be provided by the HCS Portfolio Change Management Office (PCMO). The PCMO also oversees and manages the portfolio of change within HCS, including the JCM. Portfolio updates will be reported to the Operations, Performance and |

| | |
|---|---|
| | Finance committee and the Independent Oversight Board to ensure linkage between internal and independent assurance.<br><br>Good record keeping will be essential given the application of the Freedom of Information (Jersey) Law 2011 and the likely interest in the work of the various Boards. Accordingly, appropriate measures will be put in place to achieve this, for example a dedicated board secretary and record management of group papers. |
| How does this matter relate to HCS objectives? | Delivery of the JCM is a core 2021 objective for HCS in the Government Plan and is related to the strategic objective 3 in the HCS Business Plan[1] (Improved Partnership working to deliver person-centred, sustainable and safe health and community services as detailed in the JCM) . Ensuring the programme is governed effectively will be a key factor in ensuring delivery of the programme. |

## 4. Quality and Safety implications

| | |
|---|---|
| Are there any quality or safety implications? | Design of any new or changed services will be taken through the Quality & Risk committee for assurance.<br><br>User and professional advisory groups are also proposed in the framework which will enhance a focus on quality and safety for all service design work. |

## 5. Resource and Performance implications

| | |
|---|---|
| Are there any financial, staffing or performance implications? | The Independent Oversight Board (IOB) will be staffed by externally recruited non-executive directors (or similar). The cost is estimated (by Scrutiny) at this point to be £150k per annum and will be funded through the JCM programme.<br><br>An additional post is proposed within the Change Portfolio Management Office to support the external committees – JCM Board Secretary and is within the Programme Management Team allocation of the JCM.<br><br>Other groups/boards and committees will require time and input (capacity) from HCS in order for them to achieve the functions outlined in the Terms of References for the framework. |
| Has any proposed expenditure been reviewed by Finance? | At this stage (pending confirmation of the recruitment process) budgets have not been finalised for the IOB. The programme will work with finance as we establish this process.<br><br>The internal post (JCM Board Secretary) has been reviewed with finance and |

[1] https://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/ID%20Business%20Plan%20HCS%202021.pdf

| | |
|---|---|
| | People Services. |

## 6. Risk implications

| | |
|---|---|
| Are there any associated risks? | **Reputational risk**: High level of public scrutiny on HCS processes. Mitigated through a clearly defined governance framework and working closely with the IOB to manage expectations, issues, and messages.<br><br>**Operational Risk:** Additional demands of HCS staff to support development of the programme and interaction with the governance framework. This will be mitigated through funding being made available through the JCM programme to support any anticipated capacity issues and new posts created to support the governance framework. Residual risk for 2021 as recruitment is taking place and vacancies are not filled yet will be mitigated through strong prioritisation of delivery plan for 2021. |
| What mitigations are being put in place? | As above |

## 7. Conclusion

1. Establishing the governance framework for the delivery of the Jersey Care Model is essential to ensure that external stakeholders are engaged in and inform the programme of work.

2. Getting the governance design right is critical so that it interacts smoothly with existing HCS governance processes and is compliant with legal accountability frameworks. The proposed framework has had wide review and input to ensure it is satisfactory for key stakeholders.

3. It is widely acknowledged that a governance structure now needs to be put in place and that the ways of working within each group will need to evolve and mature over time.

The proposed framework is recommended for approval on the basis that it addresses points 1 & 2 above, is lean yet effective for the scale of the programme, and has been through internal, external, ministerial, HCS Scrutiny, and legal review. It also supports the practical delivery of the programme.

## 8. Recommendation

The governance framework is reviewed and approved.

## 9. Appendices

Terms of References:

- Jersey Health and Care Partnership Group
- Clinical Professional Advisory Forum
- User Experience Panel
- Independent Oversight Board

**END**

States of Jersey
Health and Community Services

# Health and Community Services Committee Report

# Exemption: Policy under development

| | |
|---|---|
| ***Guidance on completing this report:*** | • *Complete all parts of the report template*<br>• *Ensure issues are described succinctly*<br>• *Limit the report to no more than 3 pages*<br>• *Attach any additional relevant information as appendices*<br>• *All reports to be provided 5 working days before the meeting.* |

| | |
|---|---|
| **Report to:** | HCS Board |
| **Date of meeting:** | 8th March 2021 |
| **Title of paper:** | Jersey Multi Professional Advanced Clinical Practice Framework |
| **Report author:** | Geoff White, Associate Chief Nurse |

## 1. Purpose

| | |
|---|---|
| What is the purpose of this report? | This report identifies the concept, role and outline framework supporting an Island-wide approach regarding the introduction of Advanced Clinical Practitioners (ACP's). |
| What is being asked/recommended to do/decide? | To endorse and approve an Island Wide Multi Professional Clinical Practice Framework, in line with the Jersey Care Model |

## 2. Background

| | |
|---|---|
| Why is this matter being brought? | **Context**<br>This paper supports an Island wide multi-professional approach for all care providers where Advanced Clinical Practice (ACP) is appropriate for that particular care group and where new innovative multi-professional approaches will address a 'practitioner led' model in terms of future workforce planning.<br><br>The introduction of Advanced Practice is timely, as this is one of a variety of factors which will contribute to the delivery of the *Jersey Care Model*. Multi-professional Advanced Clinical Practitioners (ACP's) will be key in providing autonomous practitioner led services, where proactive care management will enable patients and service users to receive their care across a variety of care settings including within their own homes.<br><br>Practitioner led service provision is based on contemporary evidenced based competency relevant to service specification to provide patients with the right skills, at the right time by the right person. Nationally and internationally in modern westernised healthcare systems, the introduction of ACP's in terms of providing safe and cost-efficient care outcome, have been positively evaluated.<br><br>This paper in supporting an Island wide initiative, acknowledges the value of a multi-professional approach regarding the introduction of ACP's. Likewise, this brings Jersey in line with the national agenda around advanced practice.<br><br>ACP's will be able to provide comprehensive assessment of patients and have the 'freedom to act' in terms interventions that may be required for that individual at that time. This may include prescribing prescription medicine, referral or any appropriate |

| | |
|---|---|
| | intervention that will provide a timely and high-level autonomous care outcome for that person.<br><br>The adoption of the Jersey Multi-professional Clinical Practice Framework will ensure a common understanding of advanced clinical practice island wide. The framework aims to support individuals, employers, commissioners, planners, and educators in the transformation of services to improve patient experience and outcomes.<br><br>Notably in HCS, and our current care partners FNHC & JHC, we currently have specialist practitioners working towards advanced practitioner roles. These are in speciality areas such as Drug & Alcohol, Cardiology, Rapid Response Team, ENT, Urology and Continence, Specialist Palliative Care, Sexual Health & Emergency Department nursing. Most of these staff have already undertaken the Higher Education Qualification Framework (HEQF) level 7 Independent Prescribing qualification as one core component of their Advanced Masters education pathway. ACP's will all hold a Masters qualification in Advanced Practice, which is a pre-requisite for this senior practitioner position.<br><br>**Island Wide work to-date**<br>In 2018 the Chief Nurse Office convened an *Advanced Practice Framework Oversight Group* to provide strategic oversight, direction, and governance re: the development and transformation of advanced roles to meet the current and future needs of Jersey's Care Model. This work will also link into the Jersey Workforce Strategy and considers the World Health Organisation prediction that there will be a 3 million and NHS 250,000 shortfall of registered nurses, by 2030.<br><br>The group who developed the framework included representation from partner organisations, including FNHC, JHC, the Ambulance Service and a broad cross section of professionals including the Group Medical Director, Senior Nurses and Nurse Specialists from across all organisations, Allied Health Professionals including Physiotherapists, Pharmacists & Paramedics, Trade Union representatives and Human resource leads.<br><br>Three proposals were debated and adopted by ACP oversight group:<br>• **Definition of Advanced Practice**.<br><br>• Adopting a hybrid to incorporate the Jersey context, of the **English NHS Multi-professional Framework (MPCPF) Paper (Health Education England 2017)**<br><br>• Adopting the current **Non-medial Prescribing Governance and Strategic Implementation model** for the implementation of Advanced Practice, based on the Participatory, Evidenced Based, Patient Focused, Process for Advanced Practice (PEPPA).<br><br>The introduction of the Jersey MPCPF will bring the Island in-line with the national and international agenda in terms of future healthcare reform and will be a key component to the implementation of the Jersey Care Model. |
| Who is the sponsor? Have they been fully briefed? | Rose Naylor, Jersey's Chief Nurse |
| Which assurance committee[i] or subordinate committee has this been to and were there comments / recommendations to consider? | • Developed in partnership<br>• People and Organisational Development Assurance Committee |

## 3. Key Issues

| | |
|---|---|
| What are the key issues to be aware of? | • Workforce strategy and plan<br>• Communication and agreement island wide<br>• Island Scoping exercise to identify of appropriate practitioner's island wide.<br>• Stakeholder engagement - Major change of practice, so involvement in all stakeholders who will be affected by change<br>• Educational requirement, review and provision for multi-professional Advanced Clinical Practice Masters degree |
| How does this matter relate to HCS objectives? | Role and service reconfiguration, in line with the Jersey Care Model |

## 4. Quality and Safety implications

| | |
|---|---|
| Are there any quality or safety implications? | • *Governance:* Provision of a robust governance framework around support in practice, scope of professional practice, competency assurance.<br>• *Policy Review* where ACP's scope will need to be integrated into existing policies re: vicarious liability.<br>• *Support in Practice*: Practice Supervisor Model, linked to organisational and educational requirements<br>• *Appropriate line of sight* to the Chief Nurse regarding professional issues and Group Managing director regarding operational and organisational issues. |

## 5. Resource and Performance implications

| | |
|---|---|
| Are there any financial, staffing or performance implications? | • *Workforce Planning*: Scoping and identification of future appropriate nursing, midwifery, and other allied health care professions.<br>• *Human Resource*: Review Job descriptions, job plan and employee specifications. Consider creation of 'Apprentice ACP's to 'grow' into our future ACP workforce<br>• *Review of current education provision* to mirror the ACP Four Pillars (Clinical, Education, Research, Leadership) re: fitness for purpose & practice<br>• *Business planning* around education resource and implications on business continuity (e.g. back fill).<br>• *Human resource* implications regarding clinical banding |
| Has any proposed expenditure been reviewed by Finance? | • Business Planning and scoping<br>• ACP's Job description re: job evaluation |

## 6. Risk implications

| | |
|---|---|
| Are there any associated risks? | • There is a risk of roles being developed that do not fulfil the necessary clinical, academic, and professional requirements contained within the ACP framework.<br>• Lack of professional oversight to ensure professional, regulatory, and legislative standards are upheld |
| What mitigations are being put in place? | • Oversight provided by the Chief Nurse Office, aligned to Workforce Plan and Professional Career Framework |

**7. Conclusion**

The introduction of multi-professional Advanced Clinical Practitioners is timely, as the island moves toward implementing the Jersey Care Model and explores different, cost efficient and innovative ways of delivering future healthcare. Evidence supports ACP's as a safe and cost-effective method of delivering high quality care and provides a future career framework which will optimise and develop our current registered workforce and potentially supports future recruitment and retention of a highly skilled workforce. A Job Description has been

developed and evaluated for the ACP role, which is a generic JD for nurse, midwife or AHP

**8. Recommendation**

The Board is asked to approve:

1. Introduction of an Island Wide Multi-Professional Framework for the development of Advanced Practice.
2. Endorse the Jersey Multi-professional Advanced Clinical Practice Framework Paper
3. Endorsement and recognition of the generic JD for the role for a nurse, midwife or AHP

**9. Appendices**

- Appendix 1: Jersey Advanced Clinical Practice Framework Paper
- Appendix 2: PEPPA Model
- Appendix 3: Advanced Clinical Practice (Generic) Job Description

# Multi-professional Framework for Advanced Clinical Practice in Jersey

## POD Briefing Paper January 2021


Presented by Geoff White, Associate Chief Nurse

27th January 2021

"New solutions are required to deliver healthcare to meet the changing needs of the Island. This will need new ways of working, new roles and new behaviours."

The combined Professional Bodies and Royal Colleges representing the UK Health Workforce, published a Joint Professions statement in October 2017 - this stated their shared commitment to work together in the interests of the health of the nation to build effective multi-professional teams, building summative value by playing to the strengths of the professions within teams.

https://www.aomrc.org.uk/wp-content/uploads/2017/01/2017-01-26_NCM_Academy_Joint_Statement_Action_Plan.pdf

(Academy of Medical Royal Colleges, 2017).

*"Multi-professional work requires flexibility in attitude and behaviours and for professionals to value and respect the distinct contribution each professional makes."*

*"New ways of working and delivering healthcare requires employers to ensure that clinicians have the professional development they need to adapt to changing circumstances. Clinicians need to see there are appropriate career pathways open to them to enable them to expand their contribution to healthcare and their personal job satisfaction."*

*"Evidence consistently shows that multi- professional team working delivers better outcomes for patients and more effective and satisfying work for clinicians."*

# Contents

# Foreword

This multi-professional Advanced Clinical Practice (ACP) framework sets out a new and bold vision in developing this critical workforce role in a consistent way to ensure safety, quality, and effectiveness. It has been developed for use across all settings including primary care, community care, acute, mental health and learning disabilities. This framework recognises that the health and care system rapidly evolves to deliver innovative models of care. Health and care providers and their professional workforces need to adapt to meet the increasing demands of individuals, families and communities.

In their report, Reshaping the Workforce, the Nuffield Trust identified the many benefits advanced clinical practice brings to patients, practitioners and employers but recognised the lack of clarity around the advanced practitioner role. This framework sets out to provide the clarity required for good governance, enabling employers to develop, enhance and deploy advanced clinical practice within their organisations.

For the first time in Jersey, this framework sets out an agreed definition for advanced clinical practice for all health and care professionals and articulates what it means for individual practitioners to Practice at a higher level from that achieved on initial registration. The framework sets out the capabilities expected of practitioners working at advanced level across four pillars and it describes the educational and support requirements. Finally, it provides a standardised approach to employers with advice on planning and implementing advanced clinical practice, ensuring appropriate clinical and organisational governance arrangements are in place.

Local adoption of the Jersey framework will ensure a common understanding of advanced clinical practice and will support individuals, employers, commissioners, planners and educators in the transformation of services to improve patient experience and outcome.

The organisations that have contributed to this framework have given a clear commitment to advance this agenda and support the expansion of advanced clinical practice for the future of the Health Care system in Jersey.

Rose Naylor
Chief Nurse Jersey

# Purpose

This framework builds upon the definition of advanced clinical practice in England (Health Education England, 2017). It is designed to enable a consistent understanding of advanced clinical practice, building on work carried out previously across England, Scotland, Wales and Northern Ireland.

The core capabilities for health and care professionals at advanced clinical practice are articulated in this framework. These will apply across all advanced clinical practice roles and for all professionals allied to medicines, regardless of the professional's setting, area of practice and job role. Use of the word 'capabilities' is intended to convey the extent to which health and care professionals working at the level of advanced clinical practice can adapt to change, generate new knowledge and apply it in different ways to formulate and problem solve within a context of complexity and uncertainty (Fraser & Greenhalgh, 2001).

This framework requires that health and care professionals working at the level of advanced clinical practice should have developed and can evidence the underpinning competencies applicable to the specialty, i.e. the knowledge, skills and behaviours relevant to the health and care professional's setting and job role.

The core capabilities across the four pillars - clinical practice, leadership and management, education and research are then applied to these specialist competencies (Manley 1997). These may be manifested/demonstrated in different ways depending on the profession, role, population group, setting and sector in which an individual is practising.

For the purposes of this document, hereafter core capabilities and specialist competencies will be referred to as 'the capabilities', as Advanced Clinical Practitioners need to demonstrate both capability across the four pillars and competence.

The Health Education England (HEE) National Framework has been written with the NHS in mind. The fundamental principles and opportunity for workforce transformation within this document reflect the Jersey context in terms of the need for future Advanced Practitioners in order to deliver care to the local service user population.

Transformation of the workforce will support the delivery of excellent care and health improvement to individuals and the public by optimising the way new and existing roles are developed.

The key elements of the HEE framework and a toolkit, which looks at the practical implementation of this approach, are available on the Health Education England website:

https://www.hee.nhs.uk/our-work/advanced-clinical-practice

# Context

In Jersey, the primary driver for the development of advanced practice roles is as a result of several evaluative papers which provide recommendation for addressing future trends in population demographics and an aging society.

In 2017 Skills for Health (SFH) undertook a workforce planning project across the Island. This provided a broad overview of the workforce profile and provided a systematic, objective method of reviewing required skills, roles and service redesign.

Skills for Health reviewed documents that provided the history and context across the whole health and social care economy in Jersey;

- KPMG Review 'A Proposed New System for Health and Social Services' (2011)

- P82/2012 'A New Way Forward for Health and Social Care and white paper 'Caring for each other, Caring for ourselves'.

This was preceded by a review of the different service strategies:

- Acute Services Strategy 2015-2024
- The Out of Hospital and Primary Care Strategy 2015-2020
- Mental Health Strategy 2015-2020

SFH concluded that Jersey's current position is similar to that of many health economies around the world. It is facing significant challenges in ensuring the availability of high quality health and social care services within an affordable financial envelope. They proposed that Jersey develop roles that not only maximise skills utilization and efficiency but also create interesting and rewarding career opportunities that could help with long term staff retention. The importance of this latter point cannot be ignored; all of the evidence examined clearly highlighted that recruitment and retention is a major issue across a number of services and professional groups in Jersey. There will need to be ongoing work to fully scope where advanced clinical practitioners within speciality would need to be practicing in order to optimise care delivery and achieve the required objectives.

The development of this Framework is an Island wide solution that will support the development of future roles and those already in ACP posts. This will encourage consistency and clarity and support a more standardised and coherent approach to the development and management of advanced practice.

Non-medical prescribing was successfully introduced in 2013 and has been consistently evaluated as a safe system of practice. The model used for non-medical prescribing was adapted from the PEPPA Framework (participatory, evidence-based, patient-focused process for advanced practice nursing role development, implementation, and evaluation) (Bryant-Lukosius and DiCenso, 2004).

The model was further strengthened by legislative changes providing a governance framework which included making non-medical prescribing a registrable qualification.
Patient safety and public protection are paramount and thus it is suggested that this model should similarly be used to develop the governance around advanced clinical practice in Jersey (McMahon & White, 2016).

As with non-medical prescribing, consideration will similarly be given to making the advanced clinical practice (ACP) registrable. This will ensure additional safeguards relating to governance around advanced practice. It will include mandatory requirements for re-registration including annual appraisal, demonstration of ACP role, relevance within workplace, tripartite sign off and completion of a competency based portfolio. (Non-Medical Prescribing Policy, 2013).

This Framework document will be the resource for the development, implementation and evaluation of advanced practice roles in Jersey.

The growth in advanced clinical practice roles has been accompanied by debate over how the level of advanced clinical practice should be defined and what core skills and capabilities are required.

This framework provides the agreed definition and the level of advanced clinical practice applicable to registered health and care professions in Jersey. Key principles guide the planning and development of the workforce and its governance.

A key driver for the implementation of advanced clinical practice is to enable practitioners to Practice to their full potential and to optimise their contribution to meeting population and individuals', families' and carers' needs through different models of service delivery and multi-disciplinary working.

This document has been developed as a result of wide engagement and collaboration, with contributions from multi-professional health and care professionals, employers, education and professional bodies. It draws on and consolidates existing frameworks relating to advanced clinical practice from across the UK and provides guidance and principles for current and future professionals working at the level of advanced clinical practice in Jersey.

# Section 1: The capabilities for advanced clinical practice

## 1.1 Definition

The definition of advanced clinical practice was developed and agreed by all stakeholders is outlined below:

Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making where the practitioner takes responsibility for resultant care delivery. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.

Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes. Adapted from Health Education England, 2017).

This definition therefore requires that health and care professionals working at the level of advanced clinical practice will exercise autonomy and decision making in a context of complexity, uncertainty and varying levels of risk, holding accountability for decisions made.

## 1.2 Capabilities for advanced clinical practice in Jersey

All health and care professionals working at the level of advanced clinical practice should have developed their skills and knowledge to the standard outlined in this framework; the capabilities are common across this level of practice enabling standardisation.

The four pillars that underpin this practice are:

- Clinical Practice
- Leadership and Management
- Education
- Research

The language used to describe the capabilities is deliberately mapped to level 7 taxonomy to support and make clear the expectation that people working at this level are required to operate at master's level i.e. to have the ability to make sound judgements in the absence of full information and to manage varying levels of risk when there is complex, competing or ambiguous information or uncertainty.

This framework acknowledges that the developmental pathway towards delivering advanced clinical practice may be different for individual practitioners. Health and care practitioners will demonstrate the capabilities in different ways, depending upon the nature of their scope and context of their practice, role and profession. It recognises there are many ways to gain and develop advanced practice capabilities, for further details please see the 'Education and development' section.

Listed below are the capabilities for health and care professionals working at the level of advanced clinical practice. The capabilities apply to all models of advanced clinical practice across sectors, specialties and professions and can be applied in either uni-professional or multi-professional models of care provision.

## 1.3 Clinical Practice

Health and care professionals working at the level of advanced clinical practice should be able to:

1.3.1 Practice in compliance with their respective code of professional conduct and within their scope of practice, being responsible and accountable for their decisions, actions and omissions at this level of practice.

1.3.2 Demonstrate a critical understanding of their broadened level of responsibility and autonomy and the limits of own competence and professional scope of practice, including when working with complexity, risk, uncertainty and incomplete information.

1.3.3 Act on professional judgement about when to seek help, demonstrating critical reflection on own practice, self-awareness, emotional intelligence, and openness to change.

1.3.4 Work in partnership with individuals, families and carers, using a range of assessment methods as appropriate (e.g. of history-taking; holistic assessment; identifying risk factors; mental health assessments; requesting, undertaking and/or interpreting diagnostic tests; and conducting health needs assessments).

1.3.5 Demonstrate effective communication skills, supporting people in making decisions, planning care or seeking to make positive changes.

1.3.6 Use expertise and decision-making skills to inform clinical reasoning approaches when dealing with differentiated and undifferentiated individual presentations and complex situations, synthesising information from multiple sources to make appropriate, evidence-based judgements and/or diagnoses.

1.3.7 Initiate, evaluate and modify a range of interventions which may include prescribing medicines, therapies, life style advice and care.

1.3.8 Exercise professional judgement to manage risk appropriately, especially where there may be complex and unpredictable events and supporting teams to do likewise to ensure safety of individuals, families and carers.

1.3.9 Work collaboratively with an appropriate range of multi-agency and inter-professional resources, developing, maintaining and evaluating links to manage risk and issues across organisations and settings.

1.3.10 Act as a clinical role model/advocate for developing and delivering care that is responsive to changing requirements, informed by an understanding of local population health needs, agencies and networks.

1.3.11 Evidence the underpinning subject-specific competencies i.e. knowledge, skills and behaviours relevant to the role setting and scope, and demonstrate application of the capabilities to these, in an approach that is appropriate to the individual role, setting and scope.

## 1.4 Leadership and Management

Health and care professionals working at the level of advanced clinical practice should be able to:

1.4.1 Pro-actively initiate and develop effective relationships, fostering clarity of roles within teams, to encourage productive working.

1.4.2 Role model the values of their organisation/place of work, demonstrating a person-centred approach to service delivery and development.

1.4.3 Evaluate own practice, and participate in multi-disciplinary service and team evaluation, demonstrating the impact of advanced clinical practice on service function and effectiveness, and quality (i.e. outcomes of care, experience and safety).

1.4.4 Actively engage in peer review to inform own and other's practice, formulating and implementing strategies to act on learning and make improvements.

1.4.5 Lead new practice and service redesign solutions in response to feedback, evaluation and need, working across boundaries and broadening sphere of influence.

1.4.6 Actively seek feedback and involvement from individuals, families, carers, communities and colleagues in the co-production of service improvements.

1.4.7 Critically apply advanced clinical expertise in appropriate faciliatory ways to provide consultancy across professional and service boundaries, influencing clinical practice to enhance quality, reduce unwarranted variation and promote the sharing and adoption of best practice.

1.4.8 Demonstrate team leadership, resilience and determination, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others.

1.4.9 Continually develop practice in response to changing population health need, engaging in horizon scanning for future developments (e.g. impacts of genomics, new treatments and changing social challenges).

1.4.10 Demonstrate receptiveness to challenge and preparedness to constructively challenge others, escalating concerns that affect individuals', families', carers', communities' and colleagues' safety and well-being when necessary.

1.4.11 Negotiate an individual scope of practice within legal, ethical, professional and organisational policies, governance and procedures, with a focus on managing risk and upholding safety.

## 1.5 Education

Health and care professionals working at the level of advanced clinical practice should be able to:

1.5.1 Critically assess and address own learning needs, negotiating a personal development plan that reflects the breadth of ongoing professional development across the four pillars of advanced clinical practice.

1.5.2 Engage in self-directed learning, critically reflecting to maximise clinical skills and knowledge, as well as own potential to lead and develop both care and services.

1.5.3 Engage with, appraise and respond to individuals' motivation, development stage and capacity, working collaboratively to support health literacy and empower individuals to participate in decisions about their care and to maximise their health and well-being.

1.5.4 Advocate for and contribute to a culture of organisational learning to inspire future and existing staff.

1.5.5 Facilitate collaboration of the wider team and support peer review processes to identify individual and team learning.

1.5.6 Identify further developmental needs for the individual and the wider team and supporting them to address these.

1.5.7 Supporting the wider team to build capacity and capability through work-based and inter-professional learning, and the application of learning to practice.

1.5.8 Act as a role model, educator, supervisor, coach and mentor, seeking to instil and develop the confidence of others.

## 1.6 Research

Health and care professionals working at the level of advanced clinical practice should be able to:

1.6.1 Critically engage in research activity, adhering to good research practice guidance, so that evidence- based strategies are developed and applied to enhance quality, safety, productivity and value for money.

1.6.2 Evaluate and audit own and others' clinical practice, selecting and applying valid, reliable methods, then acting on the findings.

1.6.3 Critically appraise and synthesise the outcome of relevant research, evaluation and audit, using the results to underpin own practice and to inform that of others.

1.6.4 Take a critical approach to identify gaps in the evidence base and its application to practice, alerting appropriate individuals and organisations to these and how they might be addressed in a safe and pragmatic way.

1.6.5 Actively identify potential need for further research to strengthen evidence for best practice. This may involve acting as an educator, leader, innovator and contributor to research activity and/or seeking out and applying for research funding.

1.6.6 Develop and implement robust governance systems and systematic documentation processes, keeping the need for modifications under critical review.

1.6.7 Disseminate best practice research findings and quality improvement projects through appropriate media and fora (e.g. presentations and peer review research publications).

1.6.8 Facilitate collaborative links between clinical practice and research through proactive engagement, networking with academic, clinical and other active researchers.

# Section 2: Key principles for the implementation of advanced clinical practice

## 2.1 Planning the workforce and governance

'How to ensure the right people, with the right skills, are in the right place at the right time' is a key priority to enable delivery of sustainable health and care services.

This framework is relevant for any service looking to transform its workforce to meet the needs of the population through the employment of advanced clinical practice roles. How these are integrated into service delivery and team structures for a sustainable, consistent approach to the advanced clinical practice workforce development are presented as broad principles. This is to embrace the multiple settings and roles at this level and local context. In this section, both planning and governance of this workforce are addressed.

The governance of advanced clinical practice roles is vital to their success. Good governance involves inclusive, participative decision making with clear lines of accountability and responsibility. Policies and processes need to be in place and must include the evaluation of effectiveness, impact, ongoing sustainability and responsiveness. Organisations must ensure that robust governance arrangements surrounding all types and levels of practice, are in place prior to the establishment of new roles, and these must be enhanced and strengthened for existing ones.

As stated in the definition at the beginning of this framework, advanced clinical practice refers to a level of practice. Currently many titles are used for health and care professionals who work at this level such as 'advanced clinical practitioner', 'advanced nurse practitioner' and 'advanced practice therapeutic radiographer'. It is important to note that some professionals have been given the term 'advanced' in their role descriptor, but may not be working at this level for various reasons. This may mean that employers need to review their workforce in order to make sure that there is no misunderstanding by the public and the multi- disciplinary team. Where needed, such professionals should be supported, developed and facilitated to work across all four pillars. Governance arrangements must be in place to consider these cases. Please see case examples:

https://www.hee.nhs.uk/our-work/developing-our-workforce/advanced-clinical-practice/case-studies

In order to embed advanced clinical practice and ensure its sustainability, it is necessary that the organisational governance and infrastructure arrangements include consideration of the following aspects of service transition:

- Practice governance and service user safety requirements
- Adherence to legal and regulatory frameworks
- Support systems and infrastructure for delegated roles (e.g. requesting diagnostic tests, administering medicines)
- Professional and managerial pathways of accountability
- Continued assessment against, and progression through, the capabilities identified within this framework
- Location of advanced clinical practice within a career framework that supports recruitment and retention, and succession planning to support workforce development
- Regular constructive clinical supervision that enables reflective practice together with robust annual appraisal.

The process of planning and thinking through these elements for advanced clinical practice roles in the workforce should result in the development of a business case that includes the above information and the resources required. The financial aspects should not be considered in isolation. Consideration must also be given to the ongoing support and structures that may be required to facilitate education, ongoing development, assessment and supervision (see the Education and development section).

A risk analysis and options appraisal, as well as an evaluation of the impact and effectiveness of existing and new roles should be included (see the toolkit: https://www.hee.nhs.uk/our-work/advanced-clinical-practice/advanced-clinical-practice-toolkit for further tools and examples).

## 2.2 Key principles for planning the workforce and governance:

In identifying the need for such roles and their potential impact, employers need to:

### 2.2.1 Consider where advanced clinical practice roles can best be placed within health and care pathways to maximise their impact

Historically there have been many drivers for the introduction of the level of advanced clinical practice: clinical, operational, financial and professional. However, primary consideration must be given to where this level of practice would be best placed for greatest impact in health and care pathways.

This may mean that those working in advanced clinical practice might operate outside traditional service delivery boundaries and potentially, traditional professional boundaries. The intention should be to move towards developing and planning the workforce to meet local population needs. Therefore, at the local area level, organisations should be working to generate a sustainable supply of health and care workforces who are able to work more flexibly across these boundaries.

### 2.2.2 Define a clear purpose and objectives for advanced clinical practice roles.

The level of advanced clinical practice typically exists across professional boundaries within multi-professional teams. Planning must not be done in isolation, local consideration must be given to workforce supply, existing roles and support for development. In addition, attention must be paid to the starting points for different professions relative to their core training, as well as to their duties and responsibilities. The capabilities which reflect the area of work or specialty will be required to be clearly defined.

Clinicians and service managers should be involved in planning the workforce together. Such planning should focus on the wider team, thinking about the value of the role and its purpose and objectives. Practitioners must be working to national standards, where these exist.

### 2.2.3 Consider and evaluate the impact of advanced clinical practice roles on service user experience and outcomes and on service delivery and improvement objectives.

Patient/service user and public involvement in understanding these roles, their functions and boundaries as part of the wider health and care teams, is essential and must be built into this process.

The importance of ensuring continuous improvement in the quality of care to individuals is widely recognised. It is therefore necessary to measure the impact of the activities of all staff, with a particular focus on new roles added to the workforce. The development and utilisation of robust evaluation methods is essential.

In addition, evidence demonstrating value for money and good quality of care may be required to influence senior management teams to support the introduction of new roles. This will include how the organisation or employer should quality assure itself to ensure the safety and effectiveness of the advanced clinical practice roles. For example, by using methods for monitoring and evaluating both effectiveness and impact such as, the monitoring of complaints, incidents and patient/service user outcomes and feedback. This is an essential part of governance, i.e. the observation and evaluation of intended and unintended consequences.

There are specific questions employers need to address in considering advanced clinical practice roles and to ensure good governance of those roles

- What objective outcomes are expected from the advanced clinical practice role?
- When will these outcomes be achieved and how will these be measured pre and post implementation?
- What risks and unintended consequences might there be to the introduction of this role and how may they be mitigated against?
- What resources and support are required for role development and succession planning?
- Is workforce optimised to ensure clinical and financial benefits are maximised?
- How will on-going competence and capability be reviewed and enabled? What reporting and line management structure will be in place?
- What processes will identify gaps in performance and/ or shortfalls in implementation and how will these be addressed?
- Has a quality assurance model been considered to measure this e.g. JNAAS (Jersey Nursing Assessment Accreditation System), CQC (Care Quality Commission) 5 key lines of enquiry and the local registration and inspection process in Jersey.

Thinking through these questions and finding answers will then guide governance structures and policy development but also evaluation against expected and unexpected outcomes.

### 2.2.4 Ensure clarity about the service area the individuals will work within

Understanding the level of advanced clinical practice relative to the wider team, requires the roles of all team members, i.e. those above, below and surrounding this level, to be understood. Multi-professional engagement in this work is essential to build trust, understanding, supervision and support (see the 'Education and development section' for more information on supervision). Those working in an advanced clinical practice role will need

to negotiate their individual scope of practice with service managers and the rest of the team. The wider team needs to understand the level of accountability of those in this role. To achieve these objectives there needs to be clarity and understanding as well as a proactive culture of working in partnership.

By advancing the level of practice of some staff, the people in the grades below may need some development to increase their skills and knowledge as the expectation of their role develops too. Staff in the grades above may need some support to potentially change some aspects of their role and potentially start doing some work differently. This must be understood, supported and widely communicated.

Employers also need to consider impact planning and the evaluation of the team into which the new role is introduced, and those it may impact on outside this team, reflecting on the implications for the skills mix and any changes that might be needed.

This process may then enable career and succession planning opportunities.

**2.2.5 Ensure clear and unambiguous support for the role from the organisation/ employer at all levels**

The employer must recognise the responsibilities and capabilities of someone working in these roles. This must be reflected and supported at a local and organisational level. The support must be wider than educational, the voice of those working in an advanced clinical practice role must be heard via existing or new governance and reporting structures. The board level directors, the clinical leads for the profession and managers must be aware of, understand and recognise the value of, advanced clinical practice roles. This must be cited in the governance arrangements, so that there are clear lines of professional and managerial accountability up to board level.

In addition, the employer must be aware that certain skills, e.g. prescribing, are only legally allowed for certain professions, and that this does not preclude all professions from working in an advanced clinical practice role.

**2.2.6 Develop a succession plan for future workforce.**

This should be actively supported for service sustainability, succession planning and staff retention. Clarity in the above principles will enable a clear structure to be developed and will support retention.

## 2.3 Accountability

Health and care professionals working in advanced clinical practice roles are encouraged to work to their full potential to optimise the benefits that can be gained from new models of care. Therefore, individual and organisational governance need to be robust and within legal, regulatory and professional frameworks, as there is a possibility that professionals taking on new roles and responsibilities could put people at risk. This could be caused by lack of competence to carry out duties safely or effectively, or where adequate safeguards are not in place, if these roles are not properly supported. This section examines these elements of governance which must be in place for the advanced clinical practice role.

For the purpose of this document and the point in time at which it has been formulated, this framework applies to those who have statutory registration. In order to offer clarity to the system, this work has been formulated with the regulated workforce in mind. It is understood that there are some professions that are being considered for statutory regulation and therefore are not registered at this time. Not being registered does not preclude these professional groups from working at this level but employers and employees must understand the implications and have an appropriate approach to this through safe and effective governance.

The development of advanced clinical practice roles requires that:

**2.3.1 Individual practitioners, as registered professionals, continue to hold professional responsibility and accountability for their practice.**

Work by the Commission for Healthcare Regulatory Excellence (2009) now the Professional Standards Authority, emphasised that the activities undertaken by professionals at a level of advanced clinical practice do not lie beyond the scope of existing regulation, unless the nature of their practice changes to such a significant extent that their sphere of practice is fundamentally different from that at initial registration.

Practitioners working in advanced clinical practice roles must be aware of their own limitations and through this, recognise the parameters of their scope of practice.

It is proposed that advanced clinical practice roles should reflect a set of responsibilities and capabilities which act as an indicator of a specific stage on the career development ladder. In addition, such practitioners will always be accountable to their original regulatory body, whatever the level or context of their practice. This has been reflected in the capabilities.

**2.3.2 Employers recognise and accept potential new responsibilities and greater accountability in relation to governance and support for these roles and associated level of practice.**

Governance has been mentioned in the key principles for planning the workforce and governance. It is also cited in the capabilities. It applies to all registrants and is articulated within respective professional codes of practice. Employers carry responsibility and vicarious liability for practitioners, and must be responsible for ensuring that all advanced clinical practice roles, both those that are existing and those of the future, do not compromise safety. Policies and processes may need to be modified to reflect this. Without this, there is a risk of "unconscious incompetence,

(Chapman, 2012) which may compromise safe person-centred care, as well as the reputation of advanced clinical practice.

**2.3.3 Professional support arrangements, which recognise the nature of the role and the responsibilities involved must be explicit and developed.**

Good governance regarding new role development and implementation must be based on consistent expectations and understanding of the level of practice required to deliver the service and assure safe quality standards of practice for service users. This is best achieved through the benchmarking of such posts against: agreed standards in England, best practice and the capabilities under the four pillars. Strategies such as supervision, mentorship, good record-keeping, ongoing self-assessment and development are an essential element of demonstrating accountability within practice. Existing professional support mechanisms may not be sufficient and may need to be reviewed.

These processes and strategies should be complemented by clear lines of professional responsibility and line-management and regular independent clinical reviews. Management lines of accountability may need strengthening as often staff will have a line manager separate to their team and may perhaps work across a number of teams which may add complexity and competing pressures. This must be understood and managed.

Appraisal processes may need strengthening. These processes will need to be completed in collaboration with the line manager and an appropriately qualified clinical lead. Appraisal may use evidence or feedback; clinical audit data; outcomes and issues review: productivity measures; 360 degree feedback and service user feedback.

This approach provides the most effective means of controlling risks to a patient/service user's safety from an individual professional's practice and provides a proportionate response.

**2.3.4 Employers must ensure regular review and supervision is carried out by those who are appropriately qualified to do so.**

Governance arrangements must also ensure that those who support and review practice are also developed, facilitated and supported to carry out this role.

## 2.4 Education and development

This section outlines the principles to support the development of the workforce to work at the level of advanced clinical practice. The document recognises and respects that there are many ways to gain and develop these capabilities. It aims to ensure that there are robust and clear routes to evidencing achievement of the capabilities.

Educators and employers are therefore challenged to enable capability and competence, offering an environment and a process that allows practitioners to develop abilities that are sustainable for changeability, improvability and responsiveness (Fraser & Greenhalgh, 2001).

## 2.5 Principles for education and development

At an advanced clinical practice level the attainment of both competence and capability are important:

- It is essential that practitioners are developed to be clinically competent within their specialty, sector and setting.
- Capability development is also essential: this requires practitioners to be able to recognise what level of competence is required within any given situation and apply this successfully, recognising the limits of their competence. Capability also requires the practitioner to have the ability to extend these limits when required and flexibly adapt to unfamiliar professional environments.

Local adaptation of this guidance is important to ensure workforce development is matched to local population needs, however the capabilities are deliberately stated in order to support a common understanding and expectation of this level of practice, in order to facilitate the development and mobility of this workforce at scale.

In order to meet the diverse and ever-changing workforce needs, it is essential that an outcome driven approach to developing the workforce is utilised, using the capabilities to ensure underpinning consistency and rigor. Therefore, the focus must be on the outcome, i.e. of the capabilities being met at the required level, as opposed to the developmental input or the educational process undertaken.

Education progression routes need to enable practitioners to develop and demonstrate the capabilities, recognising that this can be achieved in multiple ways, dependent upon sector, profession, setting, role and service need.

The flow chart in the 'Development routes' diagram (page 16) shows the educational routes possible to develop both clinical competence and capability.

The development of health and care professionals to enable them to operate at the level of advanced clinical practice, requires three elements within the workplace:

- **development** of competence and capability
- **supervision** and support in the work place
- **assessment** of competence and capability

## 2.6 Development of competence and capability

Practitioners and employers will need to work collaboratively to identify individual learning needs and determine the most effective route to meet these. It is essential to recognise that each profession will begin from a different starting point in their development of advanced level skills. Employers are encouraged to support practitioners to identify personal learning plans, help and meet their learning needs by supporting the:

- clear articulation of the role and scope to be undertaken
- understanding of the availability of existing speciality specific national clinical competencies or support to develop these with the clinical team
- mapping of previous education or experience against the four pillars to decide whether a practitioner's existing qualifications cover the relevant capabilities required for the level of advanced clinical practice in the health and care professional's setting, subject area and job role.
- appraisal of existing educational programmes content, approach and structure to determine match to individual requirements
- agreement of an appropriate educational approach e.g. programme of assessed work based learning and/or an academic programme
- agreement of the required work based assessments to evidence sustained attainment of the agreed capabilities in practice
- support of a named, trained supervisor, who is a specialist within the clinical area, to support the work based learning and assessment and sign off for the capabilities/portfolio.

Individuals and healthcare providers may utilise a combination of approaches e.g. work based learning, simulation or e-learning to ensure that professionals developing a portfolio to evidence advanced clinical practice get full exposure to the appropriate levels of learning. All routes are important as some health and care professionals aspiring to work in an advanced clinical practice role may have completed alternative qualifications at master's level, particularly in health and care professions that require a master's level award for registration.

Clinical training must acknowledge the importance of time and experience to build confidence in decision making and the management of risk.

It is important to note that having a master's degree does not grant the practitioner advanced clinical practitioner status. Evidenced achievement of the capabilities, employer support and a clear funded role to move into are all essential components.

## 2.7 Supervision and support in the workplace

Individuals will need to commit to the achievement of the assessment requirements for the level of advanced clinical practice, however, they will also be reliant on the support of others.

During their development individuals will require the support of an identified educational supervisor in the work place, for example a colleague working at consultant level or another appropriately qualified senior practitioner. The supervisor will provide continuity of support and an overview of the development of the individual practitioner as a whole.

Other staff may undertake supervision for shorter, focused periods of training. The supervisor and members of the wider education teams will need to be clear about the roles and responsibilities each has for day-to-day support in developing individuals, as well as being aware of their importance in nurturing and supporting the personal development of individuals.

Access to supported peer review, in addition to a supportive environment is essential and may happen within or across organisations. The use of action learning sets or learning groups offers a broader level of support.

Professionals working at a level of advanced clinical practice have a responsibility for their on-going continuing professional development. Employers will need to ensure there are opportunities for continuing professional development to ensure patient safety, the appropriate ongoing development and maintenance of capability.

## 2.8 Assessment of competence and capability

### Work Based Assessment

A key element of the preparation for individuals to practice at the level of advanced clinical practice will be a formal assessment of achievement of the capabilities, specific to the context of their practice. It is critical to the implementation, acceptance and sustainability of advanced clinical practice that health and care professionals working at this level are widely recognised as having a consistent level of competence. They must also be equally capable of fulfilling the specialist requirements of functioning at this level.

Assessment outside of formal programmes of study will need to be valid and reliable and may include: case based presentation, theoretical and/or practical tests of knowledge skills and behaviours critical reflections, portfolio of evidence etc.

To ensure assessment in the workplace is valid and reliable:

- Assessors must be occupationally competent, recognised as such by employers and education providers, and be familiar with the chosen assessment tool.

- A range of assessors, trained in the relevant assessments, should be used, including educators with appropriate academic and clinical experience and competent health and care professionals at the required level.

- Healthcare providers must invest in and support staff to undertake assessment(s) in practice.

- Work based assessment must happen within the work setting undertaken by experienced clinicians aware of the benchmark level of capability required for this level of practice, especially where a variety of professions are undertaking advanced practice skills.

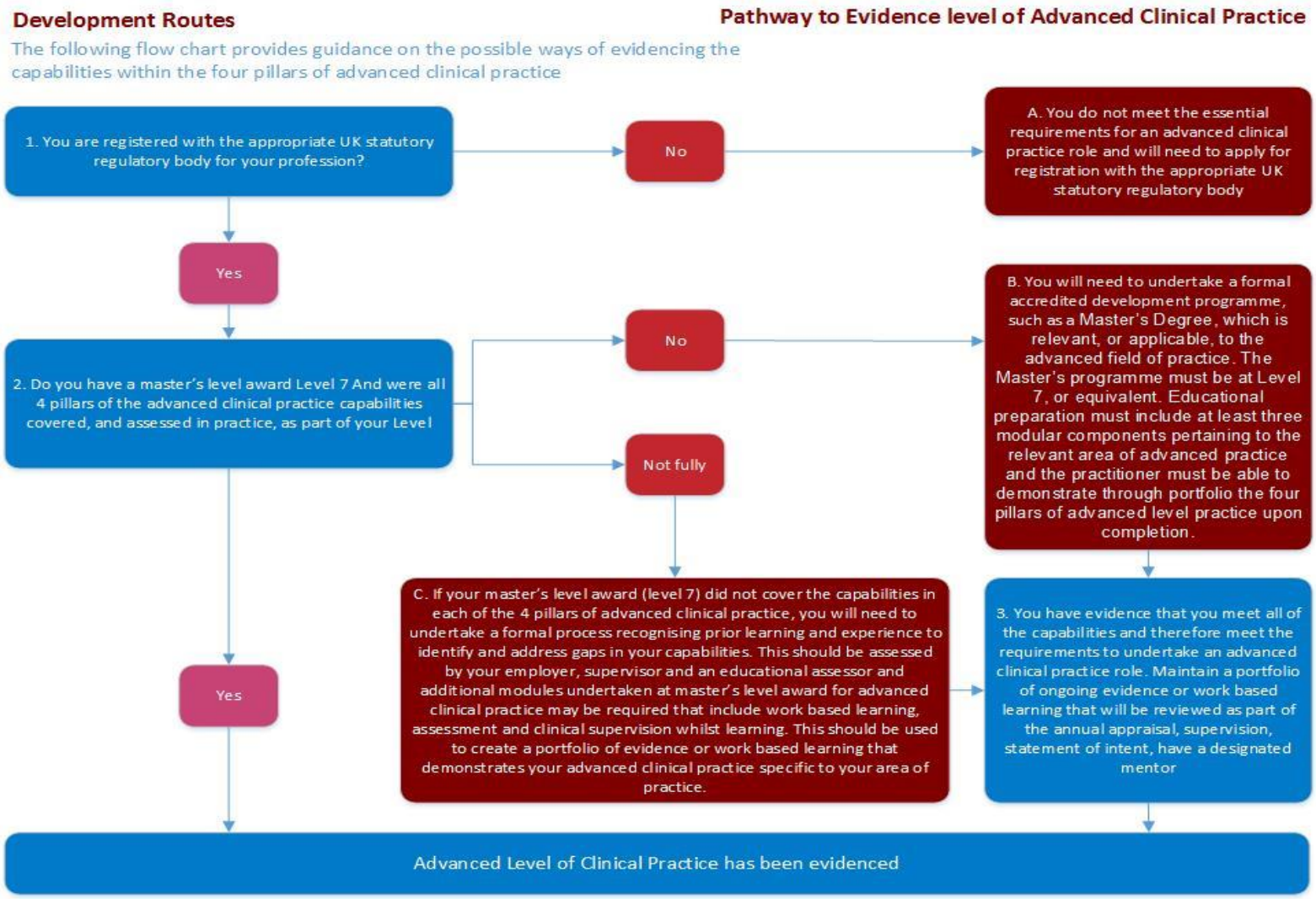
- There will be a strong need for collaboration and working across professional and organisational boundaries to ensure that learning and assessment in practice delivers practitioners who consistently meet the required outcomes in all settings.

## Assessment of a portfolio of evidence

Local arrangements are recommended and should enable local partnerships with experienced and trained clinicians, postgraduate medical educators, and Higher Education Institute (HEI) staff.

Locally we will work towards a tripartite sign off including: line manager / mentor / Island professional lead complimented by a robust supervision framework. A portfolio of evidence will be required that is compliant with the appropriate professional body and reflective and mapped against the advanced clinical practice core capabilities within the 4 pillars.

## 2.9 ACP Flow Chart



## Implications

This framework defines and sets the standard for the level of advanced clinical practice. It establishes the capabilities for this level. It also sets out a clear standard of education.

Guidance is given to employers on decision making processes that must be introduced so that they understand when and how this level of practice should be implemented. Primary consideration is given to where this level of practice would be best placed in individuals', families' and carers' journeys for greatest impact upon the planning of the workforce. Employer's responsibilities regarding processes and governance are set out.

The level of advanced clinical practice needs to be widely explained and understood, both by the rest of the workforce and by the public. Those practising at the level of advanced clinical practice, and those aspiring to this role, need to be supported by their employers and their multi-professional teams. This will encourage innovative ways of working.

This framework will be regularly reviewed to ensure remains contemporary and reflects changes locally, nationally and internationally relating to professional, legislative and practice developments relating to advanced clinical practice.

## Next Steps

The Jersey Advanced Practice Framework Strategic Oversight Group will continue to develop the strategy relating to the future introduction of ACP in Jersey.

The formulation of robust governance frameworks with development of appropriate policies and processes will be key components of this work.

Future scoping within the health system will determine where the most appropriate use of an ACP would be best placed in order to optimise patient care outcome.

Further work to formalise advanced clinical practice with a recordable qualification will continue, and is anticipated will identify minimal requirements to fulfil the criteria for local registration in Jersey.

# Appendix 1 – Glossary and Acknowledgements

## Glossary

| | |
|---|---|
| ACP | Advanced Clinical Practice |
| AHP | Allied Health Professional |
| APL | Accreditation of Prior Learning |
| Capabilities | Extent to which individuals can adapt to change, generate new knowledge and continue to improve their performance |
| Competencies | What individuals know or are able to do in terms of knowledge, skills and behaviour |
| Education Provider | A provider of higher educational services |
| HCPEL Group | Health & Care Professions' Education Leads Group |
| HEE | Health Education England |
| HEI | Higher Education Institute |
| Master's level award | This is an award that uses the relevant descriptors set at level 7 by the Framework for Higher Education Qualifications (FHEQ). This is explained here:<br><br>https:// www.gov.uk/what-different- qualification-levels-mean/list- of-qualification-levels |
| NHSI | NHS Improvement |
| NHSE | NHS England |
| Practitioner | A non-medical clinical member of the workforce who may come from any professional background |
| PSA | Professional Standards Authority |
| QAA level 7 | The Framework for Higher Education Qualifications FHEQ (2008) Qualifications Assurance Agency for Higher Education (QAA) level 7 descriptors relevant for master's level education |

## Acknowledgements

We would particularly like to thank the contributors to the following frameworks, the content of which is built upon within this document.

- NHS Wales (2010) Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales
- Scottish Government (2008, reviewed March 2013) Supporting the Development of Advanced Nursing Practice:
- A toolkit approach. (2013) CNO Directorate, Scottish Government
- Health Education England (2017) Multi-professional framework for advanced clinical practice in Jersey

**Jersey Advanced Practice Framework Strategic Oversight Group representation included:**

- Geoff White Associate Chief Nurse (Professional Practice) - Island Wide NMP Lead, Health and Community Services
- Clare Stewart Operational Lead Out of Hospital Services, Family Nursing and Home Care
- Martin McMahon Senior Lecturer, Health and Community Services
- Angela Hall Cardiac Arrhythmia Specialist Nurse Health and Community Services
- Anne McConomy Education and Development Co-ordinator, Family Nursing and Home Care
- Lesley Hill Operational Manager Physiotherapy Department, Health and Community Services
- Tim Hill Practice Development Sister, Health and Community Services
- Peter Southall Medical Consultant Pathologist Health and Community Services
- Paul McCabe Chief Pharmacist, Health and Community Services
- Peter Gavey Chief Ambulance Officer, Health and Community Services
- Michelle Nelson Deputy Director of Palliative Care Services, Jersey Hospice
- Valter Fernandez Senior Charge Nurse, Health and Community Services
- Kenny McNeil RCN Convener Health and Community Services
- Jackie Tardivel Divisional Lead Head of Nursing Ambulatory Care, Health and Community Services
- Claire Ryder Community Psychiatric Nurse Health and Community Services

# Appendix 2 – Resources (websites and documents)

Academy of Medical Royal Colleges & New Care Models Programme Workforce Joint statement: http://www.aomrc.org.uk/wp-content/uploads/2017/01/2017-01-26_NCM_Academy_Joint_Statement_Action_Plan.pdf

Commission for Healthcare Regulatory Excellence (2009) Advanced Practice: Report to the four UK Health Departments: https://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/advanced-practice-2009.pdf?sfvrsn=38c67f20_6

Department of Health (2010) Advanced Level Nursing: A position statement: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215935/dh_121738.pdf

Department of Health, Social Services and Public Safety, Northern Ireland (Oct 2016) Advanced Nursing Practice Framework: Supporting Advanced Nursing Practice in Health and Social Care Trusts https://www.health-ni.gov.uk/sites/default/files/publications/health/advanced-nursing-practice-framework.pdf

Royal College of General Practitioners (2017) What is a competent and capable doctor? https://www.rcgp.org.uk/training-exams/training/gp-curriculum-overview/online-curriculum/1-being-a-gp/what-is-a-competent-and-capable-doctor.aspx

Health Education England (2017) Framework to promote person-centred approaches in health and care: https://www.hee.nhs.uk/news-blogs-events/news/new-framework-promote-person-centred-approaches-healthcare

Health Education East Midlands (Nov 2014) East Midlands Advanced Clinical Practice Framework: https://hee.nhs.uk/sites/default/files/documents/East%20Midlands%20Advanced%20Clinical%20Practice%20Framework.pdf

Health Education West Midlands (Dec 2015) Advanced Clinical Practice Framework for the West Midlands: https://www.hee.nhs.uk/sites/default/files/documents/West%20Midlands%20Advanced%20Clinical%20Practice%20Framework.pdf

Health Education Yorkshire and Humber (Jan 2015) Yorkshire and Humber Advanced Practice Framework. http://aape.org.uk/wp-content/uploads/2015/02/HEYH-AP-Framework-Final-V1-2015.pdf

https://ficm.ac.uk/training-examinations/accps

https://hee.nhs.uk/our-work/developing-our-workforce/advanced-clinical-practice

http://www.csp.org.uk/professional-union/careers-development/career-development/professional-frameworks

https://www.england.nhs.uk

http://www.hcpc-uk.co.uk/

https://www.healthcareers.nhs.uk/about/resources/nhs-career-framework

http://www.nhsemployers.org/SimplifiedKSF

http://www.nhsemployers.org/your-workforce/pay-and-reward/pay/agenda-for-change-pay

https://www.nmc.org.uk/

https://www.qaa.ac.uk/docs/qaa/quality-code/qualifications-frameworks.pdf

http://www.rcem.ac.uk/RCEM/Exams_Training/Emergency_Care_ACP/RCEM/Exams_Training/Emergency_Care_ACP/Emergency_Care_ACP.aspx?hkey=8244ccaf-e85a-4b1e-8f8d-152484810137

https://www.rcn.org.uk/professional-development/professional-services/credentialing

http://www.skillsforhealth.org.uk/standards/item/215-national-occupational-standards

Chapman, A. (2012). Conscious competence learning model: four stages of learning theory—unconscious incompetence to unconscious competence matrix—and other theories and models for learning and change. Businessballs, Leicester, UK. http://www.businessballs.com/consciouscompetencelearningmodel.htm

Fraser S. & Greenhalgh T. (2001) Coping with complexity: educating for capability. British Medical Journal 323, 799–803

Manley, K. (1997) A conceptual framework for advanced practice: an action research project operationalising an advanced practitioner/nurse consultant role, Journal of Clinical Nursing, 6(3), pp.179-190.
Manley, K. (2002) Refining the nurse consultant framework: commentary on critique of nurse consultant framework,

Nursing in Critical Care, 7 (2), pp.84-87.

McMahon, M, White, G (2016) Introducing nurse independent and supplementary prescribing in Jersey. Nurse prescribing. Vol 14; No 6, Pages 294-299

National Leadership and Innovation Agency for Healthcare (NHS Wales) (2010) Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales. Llanharan: National Leadership and Innovation Agency for Healthcare: https://www.wales.nhs.uk/sitesplus/documents/829/NLIAH%20Advanced%20Practice%20Framework.pdf

NHS England (2014) Five Year Forward View: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHS England (2016) Leading Change, Adding Value: A framework for nursing, midwifery and care staff: https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-framework.pdf

NHS England (2017) Allied Health Professionals into Action: Using Allied Health Professionals to transform health, care and wellbeing: https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf

NHS England (2017) Next Steps on the NHS Five Year Forward View: https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

North West Workforce Modernisation Hub (2011) Defining the Advanced Practitioner role.

Nuffield Trust (2016) Reshaping the workforce to deliver the care patients need. https://www.nuffieldtrust.org.uk/research/reshaping-the-workforce-to-deliver-the-care-patients-need

Jane O'Connell, Glenn Gardner & Fiona Coyer (2014) Beyond competencies: using a capability framework in developing practice standards for advanced practice nursing, Journal of Advanced Nursing 70(12), 2728–2735.

Royal Pharmaceutical Society Faculty (2013) The Royal Pharmaceutical Society Advanced Pharmacy Framework. RPS Faculty: London. https://www.rpharms.com/resources/frameworks/advanced-pharmacy-framework-apf

Royal College of Nursing (2012) Advanced nurse practitioners: A Royal College of Nursing guide to advanced nursing practice, advanced nurse practitioners and programme accreditation. London: Royal College of Nursing. http://www.wales.nhs.uk/sitesplus/documents/861/RCN%20Competences%20Advanced%20Nurse%20Practitioners.pdf

Scottish Government (2008, reviewed March 2013) Supporting the Development of Advanced Nursing Practice: A toolkit approach. CNO Directorate, Scottish Government http://www.advancedpractice.scot.nhs.uk/media/1371/supporting%20the%20development%20of%20advanced%20nursing%20practice.pdf

States of Jersey Department for health and Social Services (2013), Jersey Non-Medical Prescribing Policy.

The Chartered Society of Physiotherapy (2011) Physiotherapy Framework: putting physiotherapy behaviours, values, knowledge & skills into practice [updated Sept 2013] http:// www.csp.org.uk/documents/physiotherapy-framework-condensed

The Mid Staffordshire NHS Foundation Trust (Feb 2013) Public Inquiry: Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

The Northern Ireland Practice and Education Council for Nursing and midwifery (2016) Advanced Nursing Practice Framework:http://www.nipec.ni.nhs.uk/Image/SitePDFS/DHSSPS%20Advanced%20Nursing%20Practice%20Framework.pdf

The Scottish Government (March 2010) Advanced Nursing Practice Roles: Guidance for NHS Boards: http://www.advancedpractice.scot.nhs.uk/media/614/sg-advanced-practice-guidance-mar10.pdf

Wessex Advanced Practice Network (October 2016) Health Education Wessex Advanced Practice Initiative. https://hee.nhs.uk/sites/default/files/documents/TVWessexAdvancedPracticeFramework.pdf

# Appendix 3 - Reference

Nuffield Trust (2016) Reshaping the workforce to deliver the care patients need: https://www.nuffieldtrust.org.uk/research/reshaping-the-workforce-to-deliver-the-care-patients-need

Fraser S. & Greenhalgh T. (2001) Coping with complexity: educating for capability. British Medical Journal 323, 799–803.

Manley, K. (1997) A conceptual framework for advanced practice: an action research project operationalising an advanced practitioner/nurse consultant role, Journal of Clinical Nursing, 6(3), pp.179-190.

NHS England (2014) Five Year Forward View: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHS England (2017) Next Steps on the NHS Five Year Forward View: https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

The Mid Staffordshire NHS Foundation Trust (Feb 2013) Public Inquiry: Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

Academy of Royal Medical Colleges (2017) Joint Professions' Statement: http://www.aomrc.org.uk/wp-content/uploads/2017/10/JOINT-PROFESSIONS-STATEMENT-111018.pdf

Health Education England (2017) Framework to promote person-centred approaches in health and care: https://www.hee.nhs.uk/news-blogs-events/news/new-framework-promote-person-centred-approaches-healthcare

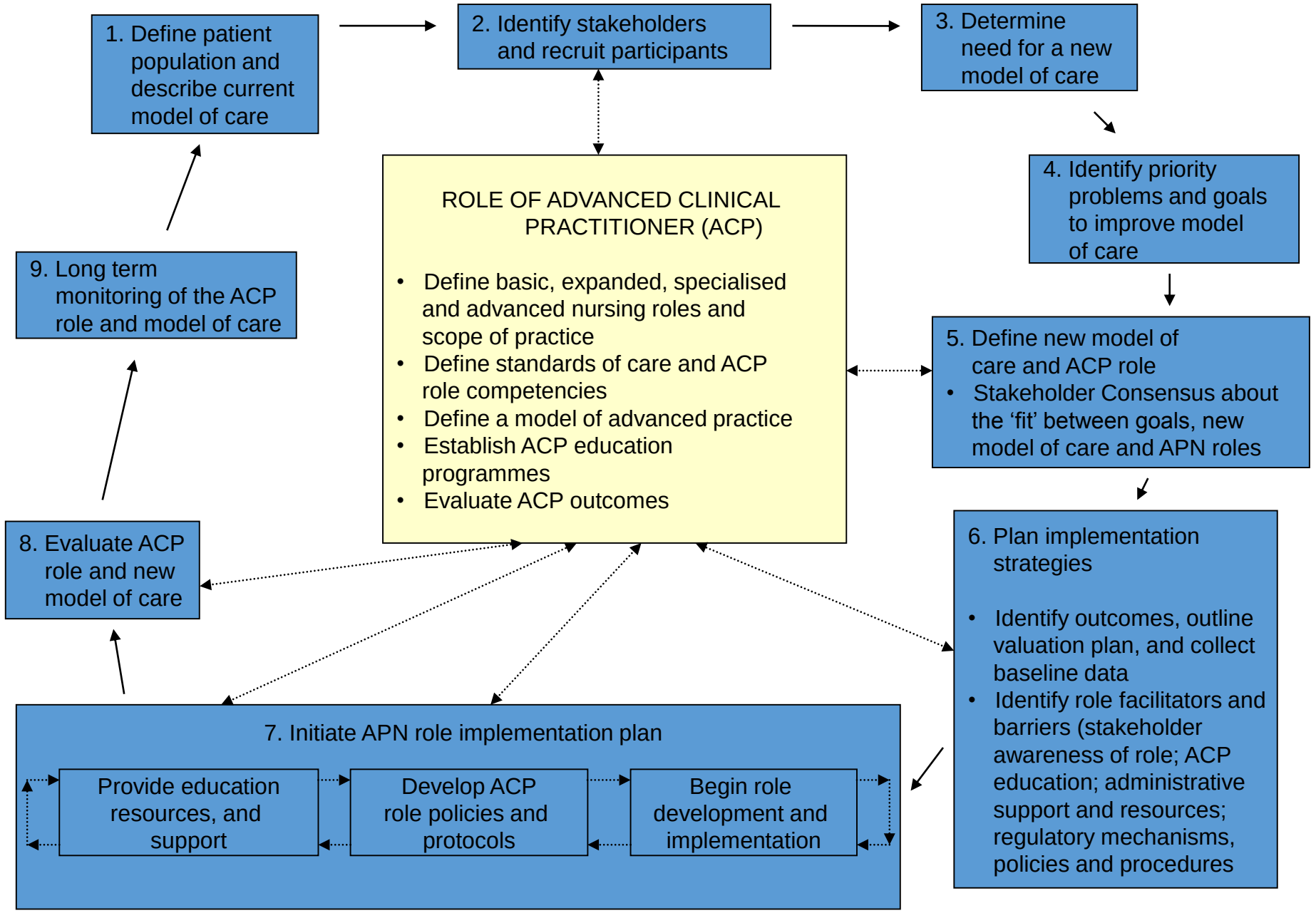
The Northern Ireland Practice and Education Council for Nursing and midwifery (2016) Advanced Nursing Practice Framework:http://www.nipec.ni.nhs.uk/Image/SitePDFS/DHSSPS%20Advanced%20Nursing%20Practice%20Framework.pdf

NHS England (2013) How to ensure the right people, with the right skills, are in the right place at the right time A guide to nursing, midwifery and care staffing capacity and capability https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

Commission for Healthcare Regulatory Excellence (2009) Advanced Practice: Report to the four UK Health Departments http://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/advanced-practice-2009.pdf?sfvrsn=6

Chapman, A. 2012. Conscious competence learning model: four stages of learning theory—unconscious incompetence to unconscious competence matrix—and other theories and models for learning and change. Businessballs, Leicester, UK. http://www.businessballs.com/consciouscompetencelearningmodel.htm

Advanced Practice (Nursing) Standards & Requirements Ireland (2017).


1. Define patient population and describe current model of care
2. Identify stakeholders and recruit participants
3. Determine need for a new model of care
4. Identify priority problems and goals to improve model of care
5. Define new model of care and ACP role
• Stakeholder Consensus about the 'fit' between goals, new model of care and APN roles
6. Plan implementation strategies
• Identify outcomes, outline valuation plan, and collect baseline data
• Identify role facilitators and barriers (stakeholder awareness of role; ACP education; administrative support and resources; regulatory mechanisms, policies and procedures
7. Initiate APN role implementation plan
Provide education resources, and support
Develop ACP role policies and protocols
Begin role development and implementation
8. Evaluate ACP role and new model of care
9. Long term monitoring of the ACP role and model of care
ROLE OF ADVANCED CLINICAL PRACTITIONER (ACP)
• Define basic, expanded, specialised and advanced nursing roles and scope of practice
• Define standards of care and ACP role competencies
• Define a model of advanced practice
• Establish ACP education programmes
• Evaluate ACP outcomes

# Advanced Clinical Practitioner (ACP)

**Department:** xxx

**Care Group:** xxx

**Reports to:** xxx

**JE Reference:** (To be completed by the Job Evaluation Team)

**Grade:** NM Grade 7 : CS Grade 12

## Job purpose

The Advanced Clinical Practitioner practices independently and in collaboration with the multi-disciplinary team as an expert Advanced Practitioner who is responsible and accountable for the management a complex patient caseload within a specialty.

Leads in providing comprehensive clinical assessment and diagnosis for the delivery of effective treatment for patients presenting with undifferentiated and undiagnosed primary/urgent health care problems.

## Job specific outcomes

1. Diagnose and perform appropriate treatment according to local and national protocols, as an independent autonomous practitioner (historically performed by a doctor). Identify abnormal test results from pathology, perform biopsies, image capture, complete pathology requests and prescribe treatment. Perform diagnostic and therapeutic interventions to agreed competency level, as agreed by the clinical lead.

2. Autonomously prescribe complex medicines management regimes including the prescribing and administration of intravenous medicine within agreed local and national protocols to patient's receiving clinical management regimes based on clinical assessment and diagnostic reasoning. As a Non-Medical Independent Prescriber, utilise highly developed specialist knowledge and skills ensuring that safe prescribing and administration of drugs occurs in accordance with current professional regulatory frameworks (e.g. NMC & HCPC) and Organisational Policy.

3. Use highly developed specialised knowledge to take Informed Consent from patients by informing them of the benefits, risks, complications and effects of the intended management regime or procedure, and any alternative treatments. Perform a comprehensive patient-focused holistic health history and physical examination. Critically analyse and interpret history, presenting symptoms, physical findings and diagnostic information to develop the differential diagnosis within the Specialist area.

4. Recognise and deal with highly complex clinical situations, recognising and initiating treatment in patients experiencing deterioration in clinical condition (physical & psychological) such as an adverse event, major haemorrhage, respiratory/cardiac arrest and acute mental health crisis.

5. Communicate highly complex and highly sensitive information to patients at the appropriate level of understanding about issues surrounding their medical condition, whilst maintaining patient confidentiality. Ensure that they understand the rationale for the proposed treatment, its consequences and any alternatives. As far as is possible, ensure that the patient understands the information given to them, overcoming any communication barriers such as deafness, learning difficulties, language skills, and demonstrate excellent levels of verbal and non-verbal communication skills. Utilise sensitive communication styles to provide reassurance, counselling and support to patients and relatives, especially when breaking bad news.

6. Communicate and liaise with primary care colleagues regarding patient care, management and monitoring, ensuring clarity of information to ensure that patient care is continued seamlessly between secondary and primary care.

7. Work collaboratively with other professionals and agencies in relation to patients' on-going care needs, liaising with a wide remit of agencies, multi-disciplinary teams in both local and UK hospitals and the community. Possess a wide knowledge of the services offered and have the authority to admit and discharge patients and refer to other health care providers as appropriate – Consultants, Clinical Nurse Specialists, Radiologists, GPs and community services.

8. Provide a nurse-led service for patients giving advice, support, counselling and prescribing for complex patients with acute, chronic and life-limiting disease. Determining, leading on the development of complex, individualised evidence-based care pathways. This will include the whole patient journey and will be undertaken in consultation with the multi-professional team and likewise, where relevant, primary and secondary care providers. This may include the admission rights for patients requiring secondary care services. Similarly, the role will necessitate leadership in complex discharge planning and assurance around seamless quality care delivery in the patients preferred place of care. This role will also be pivotal in developing public health initiatives to promote patient safety and high standard patient care outcome.

9. Responsible for receiving and disseminating highly complex information to all grades of staff, relating to patient care management. This includes in-patients as well as out-patients and day-case patients, and therefore the post holder must be highly visible in the clinical area, acting as a role model delivering high standards of patient-centred care.

10. Develop and maintain professional networks, actively seeking opportunities to promote, publicise and disseminate the ACP role and integrated working. Provide clinical leadership, expert practice and advanced knowledge, integrating research evidence into practice and contributing to/leading on research in their clinical field. Act as a resource and teach on under and post graduate educational programmes relevant to the role.

11. Challenge colleagues in specific aspects of practice contributing to the support and development of others through collaborative working, planning and delivering interventions that meet the learning and development needs of the wider team.

## Statutory responsibilities

Active engagement, participation and compliance with any other statutory responsibilities applicable to the role, as amended from time to time.

This role is politically restricted. The job holder is not permitted to undertake political activity involving standing for election to the Government or as a Parish Constable, or publicly supporting someone who is standing for election or playing a public part in any political manner.

## Organisation chart

*Insert an organisation chart showing this role and its line managers and reports (individual names must not be included only post titles)*

# Person Specification

## Specific to the role

| ATTRIBUTES | ESSENTIAL | DESIRABLE |
|---|---|---|
| **Qualifications**<br>*Please state the level of education and professional qualifications and / or specific occupational training required.* | Regulated Health Care Professional with current registration<br><br>Master's degree in advanced clinical practice; the curricula must include the 4 pillars of advanced practice<br><br>Nationally accredited Independent Prescriber qualification with relevant regulator<br><br>Minimum 5 years' experience at senior level<br><br>Intermediate Life Support (ILS) Advanced Life Support (ALS) if hospital based) | Supervision/leadership/mentoring training or qualification<br><br>Advanced Life Support (ALS)<br><br>Recognised Teaching and assessing Course<br><br>Speciality specific qualifications e.g. Sick child, Chronic disease. |
| **Knowledge**<br>*This relates to the level and breadth of practical knowledge* ***required*** *to do the job (e.g. the understanding of a defined system, practice, method or procedure).* | Knowledge of local and national healthcare agendas/strategy and policies and how they relate to the specific service.<br><br>Understand the legal, ethical and professional responsibilities and accountability with regards to advanced level, autonomous practice.<br><br>Significant post registration experience where autonomous working at advanced level has been acquired | Ability to undertake ethically compliant research |

| | | |
|---|---|---|
| | in the speciality areas or a relate areas where advanced skills could be transferrable.<br><br>Understand the impact of advanced practice roles on service delivery and their contribution to the multi-professional team.<br><br>Knowledge and understanding of clinical and human factors in the delivery of safe healthcare practice<br><br>Highly developed advanced clinical knowledge and skills, underpinned by theory and experience.<br><br>In depth service specific knowledge which underpins advanced level practice.<br><br>Candidates must display expert level knowledge of the Governance and Risk frameworks required to underpin the delivery of safe patient care.<br><br>Experience of leading evidenced based service improvement and innovation through service/practice development initiatives, audit or research. | |
| **Technical / Work-based Skills**<br>*This relates to the skills specific to the job, e.g. language fluency, vehicle license etc.* | Ability to engage with people and motivate and support them to work to high standards. | |

| | | |
|---|---|---|
| | Calm under pressure, able to use initiative and make decisions.<br><br>Excellent interpersonal /communication skills with a variety of media and at all levels. This includes the ability to communicate in difficult and challenging environments.<br><br>Thorough and up to date knowledge of best practice, and the application of this practice<br><br>Understanding and application of Regulated Code of Practice and requirements of it for the practice and behaviour of staff and self,<br><br>Keyboard skills, skills required for professional practice<br><br>Holder of full driving licence | |
| **General Skills/Attributes**<br>*This relates to more general characteristics required to do the job effectively, e.g. effective written communication skills, ability to delegate, motivation or commitment etc.* | Competent IT and keyboard skills<br><br>High level reasoning skills and ability to problem solve.<br><br>Organised with effective time management; adaptable and self-motivated.<br><br>Ability to present effectively both verbally and in writing<br><br>Ability to plan and organise complex programmes that may | |

| | | |
|---|---|---|
| | require urgent responses<br><br>A strong team player who can professionally lead and role model. | |
| **Experience**<br>*This is the proven record of experience and achievement in a field, profession or specialism. This could include a minimum period of experience in a defined area of work if required by an external body (for example a period of post-qualification experience).* | Significant post qualification working experience in order to have developed consolidated practice to lead the staff teams.<br><br>Experience of working in an autonomous practitioner role at a Senior level with relevant clinical and management experience<br><br>Experience of developing business cases/business planning<br><br>Experience of implementing, managing and achieving changes in clinical practice<br><br>Demonstrable experience of developing staff and teams<br><br>Experience of designing and delivering training to colleagues at all levels | Clinical supervision/coaching skills<br><br>Experience of work using telephone triage |
| **Criteria relating to Safeguarding**<br>*Other requirements needed to confirm suitability to work with vulnerable people e.g. attitudes, skills, experience etc.* | Applied knowledge, training and experience of safeguarding. | |

## Core Accountabilities, Attributes and Behaviour Indicators

**Delete as appropriate:**

.

Appointees to this role will be required to adhere to and perform their duties in line with the standards identified in the States of Jersey tier 4 core accountabilities attributes and behaviour indicators.

**This next section is for Job Evaluation purposes only (Please remove everything below this point when using the JD elsewhere e.g. for recruitment / consultation purposes)**

# Additional job information

## Specific to the role

The following sections are included to ensure that a complete picture of the job can be gained for job evaluation purposes. The requirements of the job are summed up in the preceding sections; nothing in the following sections should sit at odds with the earlier information to word count for each element should be no more than 100 words. The Additional job information section will be removed once the job has been evaluated.

| ***Communication and Relationships*** |
|---|
| The post holder will receive highly complex, sensitive or contentious information to individuals - patients, families and staff. Needs to be able to display empathy especially at times of distress and will be required to impart same information to others in an appropriate way.<br><br>The post holder needs to be able to effectively counsel and support colleagues at times of difficulty, distress or challenge in order to ensure continued delivery of safe services.<br><br>Communicate effectively with key stakeholders this will require the post holder to have highly competent skills in negotiation, motivation, persuasion skills, presentation skills, and listening skills.<br><br>Communicate with clinical professional colleagues, politicians, the media, professional bodies, Jersey Care Commission and staff side organisations.<br><br>Positive working relationships are key to developing new services, managing existing services and safeguarding those in our care and requires key influencing skills.<br><br>Provides the professional advice and support to others in relation to professional and practice matters, ethical issues.<br><br>Ability to communicate with all levels of staff from Board to ward level using appropriate language |

| ***Analytical Skills*** |
|---|
| Specific analysis and interpretation of service metrics and outcomes requiring specialist technical knowledge throughout every aspect of the patient journey through their care journey, to define efficiency and effectiveness of service areas. |

Understand the complexities of clinical areas, multiple agency involvement alongside service user preferences.

Utilises highly developed knowledge of current nursing and professional issues to rapidly grasp the complexity of situations to determine underlying causes and identify appropriate solutions these maybe multifaceted and there needs to be an ability to change if the situation alters.

The post holder will be required to present solutions in a rational and logical manner and may need to decide the cause of action autonomously.

Situations maybe complex and sensitive, involve political agendas and may attract media attention, for example serious incidents requiring immediate action and decision making. Involvement in safeguarding cases, investigations and serious case reviews, representing maternity services, ability to participate in an objective and impartial way, drawing on evidence and practice from elsewhere.

The post holder will be required to investigate and analyse data relating to disciplinary investigations, complaints, serious incidents, safeguarding concerns making sure that appropriate action is taken and act where standards have been breached as appropriate to local policy.

Analysis of detailed reports, writing business cases, strategy, reading and answering emails

***Planning & Organisation***

Planning skills required to align service provision with staff resource, considering large variability in patterns of working, such as rotas.

Ability to adapt or direct resource as required to fulfil service needs which are liable to constant fluctuation with service pressures.

Lead regular operational meetings to ensure service delivery to all areas of care group and reduce areas of clinical and non-clinical risk, responding appropriately to changing organisational demands and priorities.

Ability to be responsive to changing organisational demands and priorities.

The post holder will be required to identify areas for improvements for the Care Group and produce high quality reports and business cases to support initiatives.

The post holder will be required to develop short, medium and long term plans for the Care Group.

The elements of the role will include, planning organising and prioritising own and team workloads and deal well with uncertainty and interruptions which may disrupt their work plan and priorities due to the urgent requirement to respond.

| |
|---|
| Delegate appropriately to competent colleagues, retaining overall responsibility for completion of the task |

| ***Physical Skills*** |
|---|
| Standard keyboard usage.<br><br>Able to demonstrate safe use and cleaning of medical equipment.<br><br>May be required to travel to different sites around the island. |

| ***Policy and Service Development*** |
|---|
| Develops and implements policies in order to support organisation change and service delivery.<br><br>Developing and delivering patient engagement strategies in support of developing service improvements.<br><br>Ensure that clinical services are appropriately aligned with good practice.<br><br>Support the shaping and development of services within the care group through the delivery of a competent, flexible, motivated workforce.<br><br>Participate in driving and facilitating transformational change across HCS<br><br>Will demonstrate a thorough knowledge of the guidelines of relevant regulatory Code, set by the regulatory body. The post holder is required to work within the Code. |

| ***Financial and Physical Resources*** |
|---|
| Effective budgetary management amongst the delegated budget holders to ensure that service provision is financially sustainable.<br><br>Promotes a culture of sustainability, cost effectiveness, value for money and budgetary control.<br><br>Operates within and ensures compliance with financial directions and other relevant standing orders.<br><br>Employs flexible and innovative use of resources to deliver improved outcomes.<br>Leads effectively and manages any identified or allocated cost saving schemes and contributes to the overall HCS savings programme. |

| ***People Management*** |
|---|
| |

Manages staff in accordance with HR policies and procedures and will support staff to select and appoint with the necessary skills, and values.

Co-ordinate staff development and use the appraisal, performance review and revalidation to continually improve performance.

Ensure all team members are registered with the appropriate regulatory bodies including Jersey local registration and able to maintain their registration through appropriate revalidation.

Ensure that mandatory and statutory training is in place for staff in matters relating to infection prevention and control and that compliance is monitored.

Ensure that team mandatory and statutory requirements are met

***Information Resources***

Responsible for maintaining own work records and records personally generated information.

Will be required to act as an investigator and oversee actions and improvements relating to infection prevention and control, relevant FOI requests, States Questions, Subject Access Requests.

Be competent in the use of healthcare software packages, and the information contained.

Be compliant with information governance.

***Freedom to Act***

Works autonomously under self-direction to ensure services are delivered to the professional standards expected to ensure patient safety

Work independently to deliver to agreed timeframes.

Make balanced judgements based on all of the facts and information available.

Autonomously plan and organise a wide range of tasks, activities, clinical and non-clinical

Responsible for maintaining own work records and records personally generated information.

***Physical Effort***

Is required to be highly visible in clinical areas – this includes, bending, lifting, leaning, moving beds, sitting, standing for long periods of time

***Mental Effort and Concentration***

| |
|---|
| Ability to concentrate when being frequently and unpredictably interrupted by clinical staff with requests/problems<br><br>Ability to concentrate on occasions for prolonged periods when working on detailed documents.<br><br>Be adaptable and cope with unpredictable changes to workload, remaining calm and approachable. |

| ***Emotional Effort*** |
|---|
| Must be able to deal with distressed relatives and patients on a daily basis.<br><br>Ability to deal with sometimes stressed staff working with critically ill patients.<br><br>Investigation of serious clinical incidents.<br><br>Dealing with sensitive patient information.<br><br>Communicating life changing events using specialist and complex information. |

| ***Working Conditions*** |
|---|
| Exposure unpleasant substances / non-household waste occasionally during ward visits.<br><br>Patient body fluids, vomit occasionally during ward visits.<br><br>Visits to homes of those who have used services or staff – these could be angry, distressed, aggressive, upset.<br><br>May be requested to support the service in the event of major incident. |

| ***Any other information***<br>*Include any information that you believe is important to ensure that we have a sound understanding of the role that is not included anywhere else in the form.* |
|---|
| |

## Organisational structure

| | |
|---|---|
| **Date of Evaluation** | xxx |
| **Post Number** | xxx |
| **Post Band** | xxx |