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FOREWORD

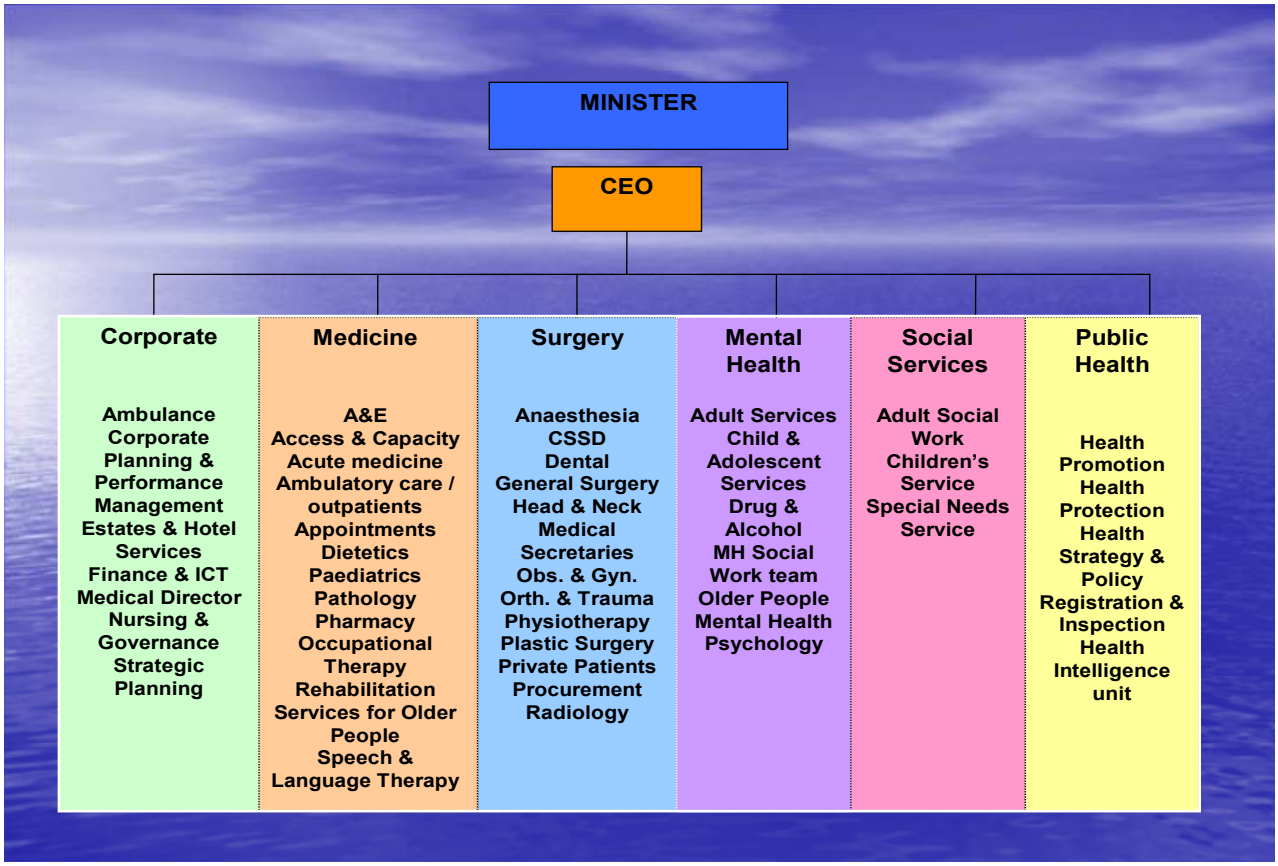
I am pleased to present the 2007 Business Plan for the Department of Health and Social Services. The plan sets out what we aim to deliver in the year ahead and provides the framework by which we will be held to account for what we achieve. It reflects a wide range of important improvements that are being made to our services.

The dedication and commitment of staff throughout the organisation enables us to continuously improve the quality of care we deliver, as attested by external bodies who inspect and accredit our organisation, from patient survey's, and from my direct conversations with patients and clients. This is a major strength of our organisation and I would like to personally thank all staff and volunteers who help us achieve this. My thanks extend to those workers in the charitable and voluntary organisations who provide much needed health and social care services in partnership with the Department for Health & Social Services.

Stuart Syvret

Minister, Health & Social Services

HIGH LEVEL ORGANISATIONAL STRUCTURE



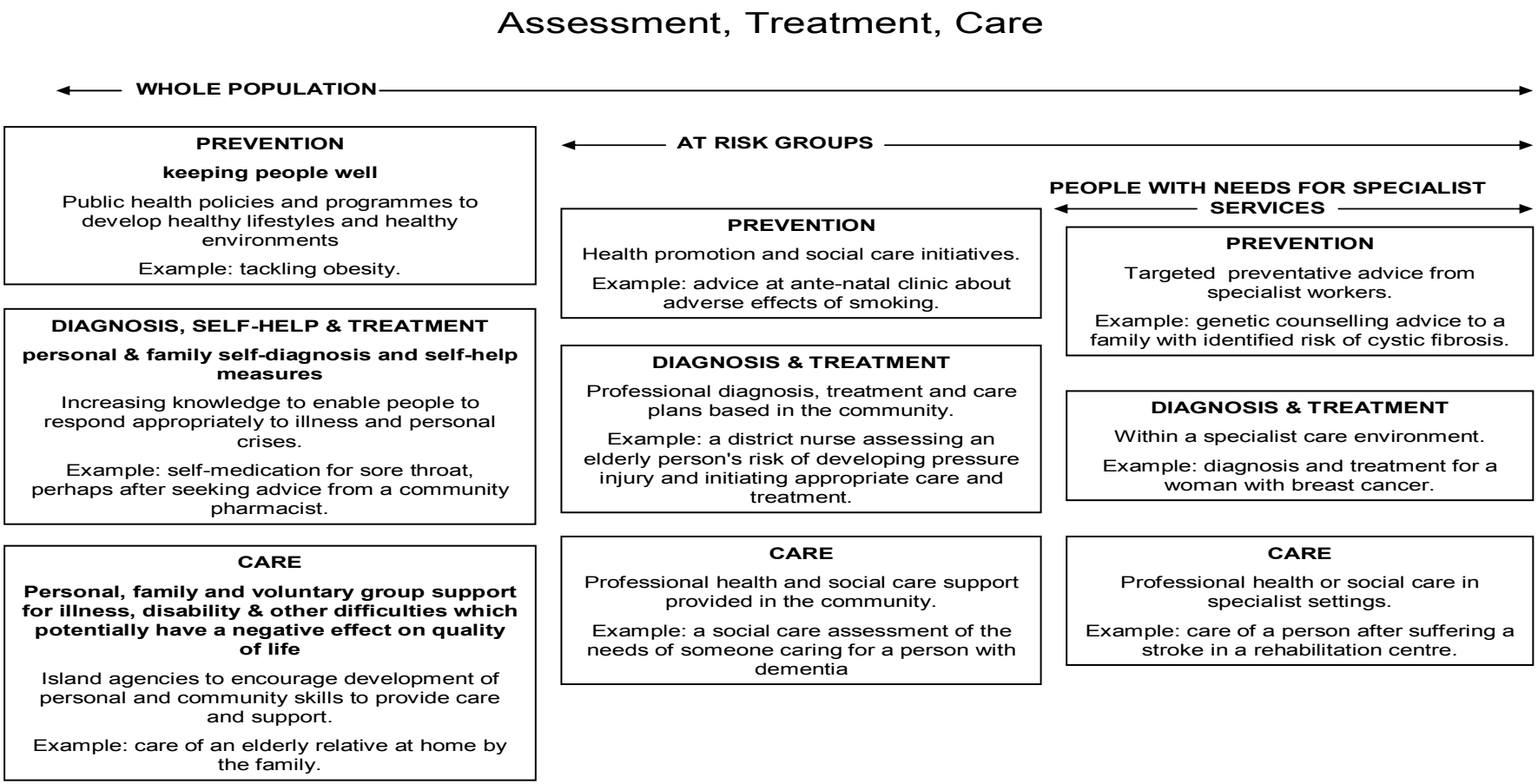
Key primary legislation related to Health and Social Services are as follows:

1.	Adoption (Jersey) Law 1961
2.	Children (Jersey) Law 2002
3.	Cremation (Jersey) Law 1953
4.	Food Safety (Jersey) Law 1966
5.	Food Safety (Miscellaneous Provisions) (Jersey) Law 2000
6.	Health Care (Registration) (Jersey) Law 1995
7.	Hospital Charges (Long Stay Patients) (Jersey) Law 1999
8.	Maladies Vénériennes, Loi (1919) sur le traitment des
9.	Medical Practitioners (Registration) (Jersey) Law 1960
10.	Medicines (Jersey) Law 1995
11.	Mental Health (Jersey) Law 1969
12.	Misuse of Drugs (Jersey) Law 1978
13.	Nursing Agencies (Jersey) Law 1978
14.	Nursing and Residential Homes (Jersey) Law 1994
15.	Pharmacy and Poisons (Jersey) Law 1952
16.	Piercing and Tattooing (Jersey) Law 2002
17.	Public Health (Vessels and Aircraft (Jersey) Law 1950
18.	Santé Publique, Loi (1934) sue la
19.	Statutory Nuisances (Jersey) Law 1999
20.	Termination of Pregnancy (Jersey) Law 1997
21.	Anatomy and Human Tissue (Jersey) Law 1984
22.	Consent to Medical Treatment (Jersey) Law 1973
23.	Dentists (Registration) (Jersey) Law 1961
24.	Opticians (Registration) (Jersey) Law 1962

SECTION 1

1.1 WHAT WE DO

To improve the health and well-being of people of Jersey, services need to be in place to cater for the whole population. This includes those who are at risk or people who have an established disability, illness or social need. The diagram below illustrates how different elements of health and social services work together to meet the needs of the whole population. Many people who use health and social services have complex needs which do not recognise organisational boundaries.



1.2 STRATEGIC AIMS

The Department is currently developing a new Strategy –'New Directions', that will replace 'Improving health and social care' 2001/2005.

Until this is finalised the overall aim of the department and key objectives is as set out in the States Business Plan 2007/11 as follows:

AIM

To redesign the health and social care system to deliver improved health and social well being for the Island community

Objective 1: Improve health and social care outcomes by reducing the incidence of mortality, disease and injury in the population.

Objective 2: Improve the consumers' experience of Health and Social Services.

Objective 3: Manage staff and resources so as to improve performance and provide value for money.

Objective 4: To promote the independence of adults needing social care enabling them to live as safe, full and as normal a life as possible, in their own home wherever feasible.

Objective 5: To maximise the social development of children within the most appropriate environment to meet their needs.

1.3 VALUES

STATES VALUES

- We put the customer at the heart of everything we do
- We take pride in delivering an effective public service for Jersey
- We relentlessly drive out waste and inefficiency
- We will always be fair and honest and act with integrity
- We constantly look for ways to improve what we do and are flexible and open to change
- We will achieve success in all we do by working together

1.4 INTRODUCTION BY THE CHIEF EXECUTIVE

1.4.1 I am pleased to present our Business Plan for 2007. This business plan is a record of what key changes and improvements are anticipated in the year ahead, rather than an inventory of all of the activities essential to the operation of health and social services.

This particular section focuses on a number of **key issues** facing the department and demonstrates how we are responding to them; they are linked to the objectives in section 2.2 were a full set of **objectives** can be found.

I am committed to achieving the results laid out in this Business Plan.

1.4.2 Key challenges

1. Financial implications 2007/09
2. Demographics and demand
3. Strategic direction
4. Business planning & performance management
5. Governance
6. Public health
7. Pathology services
8. Day surgery
9. Substance abuse
10. Suicide prevention strategy
11. Fostering and Adoption Services
12. Develop Homefinding team and support services
13. Crisis intervention - special needs
14. Adult Residential Care – special needs service
15. Development of community care services – Adult social work

CORPORATE

1. Financial Implications 2007/09

As with most health and social care systems in the developed world, Health and Social Services are subject to continuing pressures from a number of sources which have a direct impact on the cost and demand for services. These include:

• an ageing population;

• advances in medical science and technology resulting in new high cost diagnostic and therapeutic interventions;

• investment in IT services required to deliver modern, efficient and effective services;

• increasing public expectations and;

• rising standards in clinical practice.

Against a background of sustained investment by the UK Government in the NHS the Health and Social Services and Policy and Resources Committees sponsored a review of health care funding, undertaken by the Health Services Management Centre, University of Birmingham. In 2003 the report recommended that the service required real growth of between 3% and 7% for the next five years.

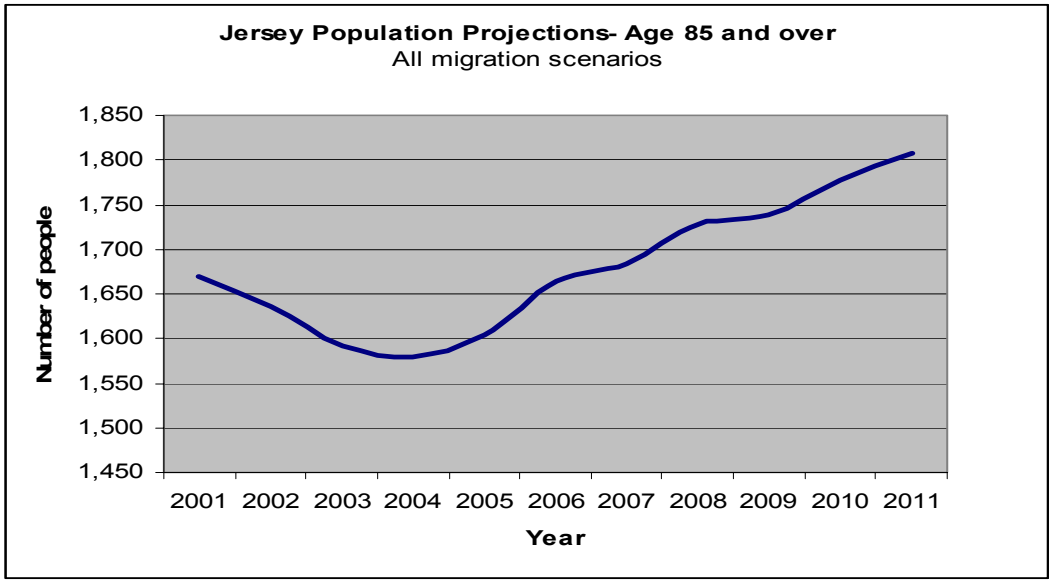
The 2007 cash limit provides growth of £3.3 million, equating to 2.5% growth on the 2006 cash limit whilst also requiring efficiency savings of £0.9 million. This clearly presents a difficult financial environment in which to operate. Maintaining and improving services in terms of both volume and quality whilst at the same time meeting the cost and demand pressures outlined above will prove extremely challenging. The department has a track record of successfully meeting these challenges; for example, 2006 has seen a dramatic reduction in waiting times for all elective surgery. The department aims to continue to successfully meet these challenges and will both continue and commence with the implementation of a number of initiatives during 2007.

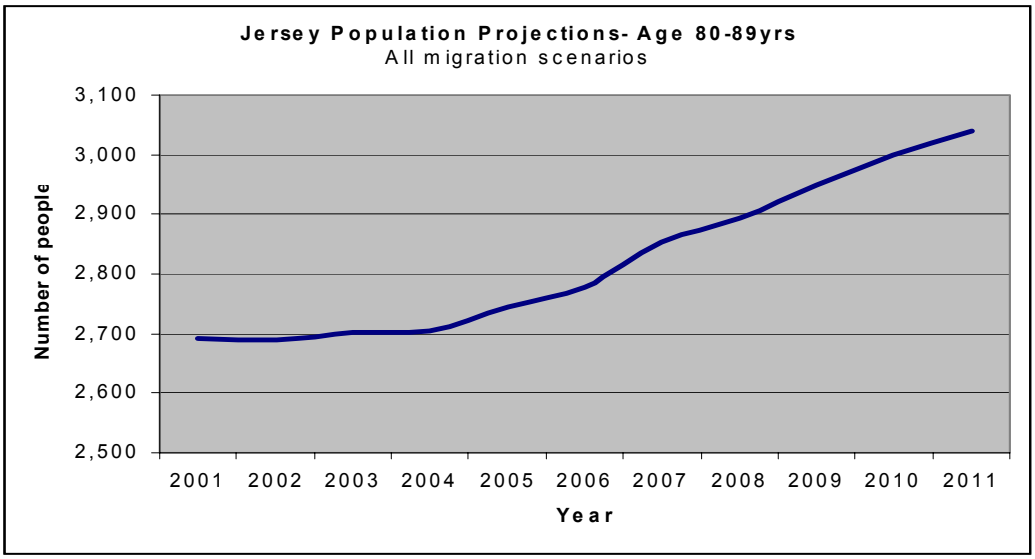
2. Demographics and Demand

Demographics

As cited in the previous business plan, Jersey's population is ageing with the fastest growing sector of the population are those 85 years and over. The full effects of this demographic change are likely to present increased demand over the next 5 years'. There was a temporary dip in the numbers of over 85 year olds between 2001and 2004 as a result of the reduced birth rate during World War 1. However, we can expect a resurgence of demand for care from 2005 as the numbers of those aged over-85 resume their ascent. The "dip" in the 85+ cohort is shown in the first graph below. Its impact upon a general upward trend in the 80-89 yr old cohort is shown in the second graph below. The age group also has some of the greatest requirement for care services with patients normally suffering with chronic and multiple needs.

In general we will need to plan for age-related illnesses including, cardiovascular diseases, cancer, diabetes, renal failure, cognitive impairments (dementia), cataracts and musculoskeletal diseases (specifically, hip, knee replacements and arthritis).

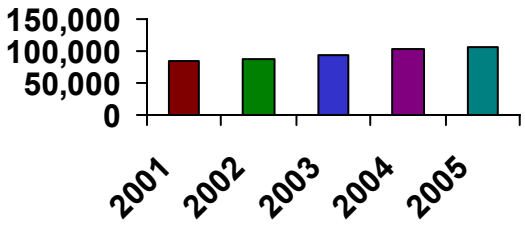




Rising demand (some facts and figures)

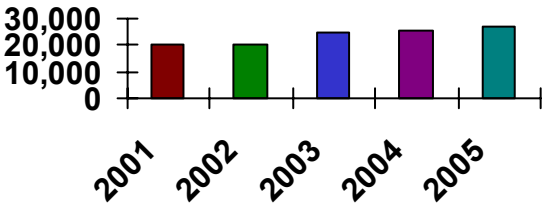
ALL OUTPATIENT ATTENDANCES

Outpatient attendances have risen 28% in 5 years from 84,062 in 2001 to 107,617 in 2005.



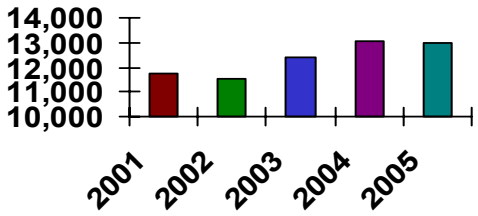
INPATIENT/DAY CASE DISCHARGES

Inpatient/day case discharges have risen 36% in 5 years from 20,078 in 2001 to 27,280 in 2005.



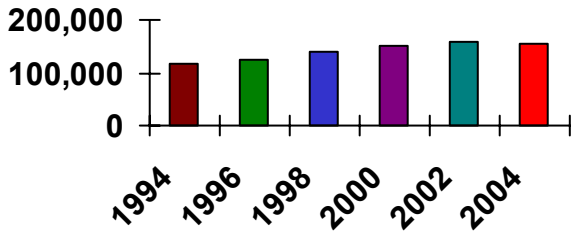
OPERATIONS/PROCEDURES (MAIN, DAY SURGERY, ENDOSCOPY)

The volume of operations and procedures has risen by 11% in 5 years, with 12,981in 2005 compared to 11,717 in 2001.



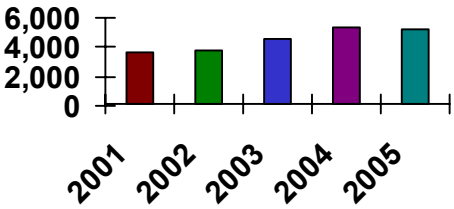
PHARMACY PRESCRIPTIONS

155,395 prescriptions were issued by pharmacy in 2004 compared to 118,514 in 1994, an increase of 31%.



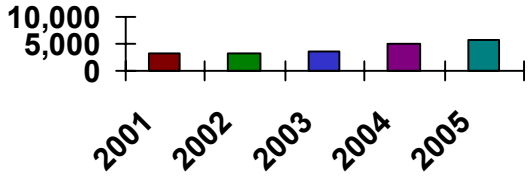
MRI EXAMINATIONS

The number of examinations has risen by 44% from 3,628 in 2001 to 5,240 in 2005.



CT SCANS

There has been a 92% increase in CT scans from 3,042 in 2001 to 5,837 in 2005.



To manage future levels of demand, improve access to services and meet public expectations it is vital that we continue to review our current capacity requirements and plan future capacity in line with these changing demands. A number of initiatives have been undertaken as reported in previous business plans whilst others are in progress.

Some current reviews include:

- Diabetes services
- Screening services
- Cancer services

3. Strategic Direction

One of the most important objectives cited in the States of Jersey's Strategic Plan is for Health and Social Services – working with other departments and a wide range of stakeholders – to bring forward detailed proposals for the redesign of the Island's health and social care system. There is an expectation that these proposals will include clear indication as to how these services should be funded in the longer term and what structures might be required to organise the delivery of a range of services appropriate to an Island community in the 21st Century.

New Directions is a programme which will lead to proposals for the re-design of the health and social care system in Jersey ensuring that it is "fit for purpose" for the next ten to fifteen years. It is informed by the analysis of a number of challenges including: • How can Jersey best manage the effects of structural

changes in its population – the “demographic time bomb”. • Sub-specialisation in medicine and sustainability given the relatively small population. • Changing needs and meeting increased public expectations. • The level of funding required - particularly managing the impact of the ageing of the Jersey population. Through a process of 'scenario’ planning' a number of policies are becoming clear including 1. The need for substantial investment in the management of chronic disease. 2. Services which maximise the patient or client’s independent living. 3. The 'Sustainable Hospital’, which will involve the re-design of how emergency and elective care is managed 24/7.

4. Business Planning & Performance Management

The States has an agenda for the radical reform of public services and has put a new emphasis on service delivery. The States Strategic Plan has set the strategic direction for the States from 2006/11. Departmental business plans will translate these strategic aims and aspirations into firm, deliverable objectives. In addition to this process is the complimentary performance framework (balanced scorecards) being developed States-wide.

We will ensure our business and service plans are aligned to our strategic direction which itself will encompass the States Strategic Vision 2006/11.

HSS developed a Corporate scorecard back in 2005 which has been revised to meet the new ‘States-wide’ requirements. Directorate scorecards are being developed and will be implemented during 2007. These Scorecards will provide quarterly performance information and over time this system will provide comprehensive information on the quality and performance of the department, directorates and service areas.

5. Governance

The NHS has faced a series of scandals and medical disasters in recent times - including failure to detect and report life-threatening clinical conditions and unacceptably poor outcomes for some surgical procedures. In addressing these failures a new quality assurance system was introduced into the NHS to protect the interests of patients and to support health professionals in providing high quality care. This system is known as “Governance” and covers an organisation’s systems and processes for monitoring and improving services. The components of this system are set out below

- clinical risk management
- clinical audit
- research and clinical effectiveness
- consultation and patient involvement
- staffing and staff management
- education, training and continuing personal and professional development
- external validation (inspection)
- the use of information about the patients’ experience, outcomes and processes
- legislative requirements

Some Governance issues are expanded on here and how we are responding.

Healthcare Commission (external validation)

One component of governance is to be quality assured by a competent external validating agency - such as the Healthcare Commission.

The Healthcare Commission came into being in April 2005 and brought together both the Audit Commission and the previous inspectoral body known as the Commission for Health Improvement.

Health and Social Services will embark upon a rolling program of service reviews carried out by the Healthcare Commission and benchmarked against all UK Trusts. The areas for review in 2007 are:

- Maternity Services
- Inpatient Mental Health Services

- Substance Misuse Services
- Race Equality

We will publicly declare our performance in these reviews in addition to any development plans deemed necessary to address areas of poor performance.

Through this process we will continuously improve the quality, effectiveness and efficiency of our services.

Legal requirements

a) Medical staff – registration / licensing / revalidation

The General Medical Council (GMC) is in the process of reforming the system of registering medical practitioners in the UK. The preamble to the first Medical Act of 1858 in the UK stated: 'It is expedient that persons requiring medical aid should be able to distinguish qualified from unqualified practitioners'. To be qualified then meant holding a medical qualification that was accepted for registration. Little has changed since – doctors are still admitted to the register on the strength of their qualifications or by an assessment of their capability for practice if they have obtained their qualifications outside the European Economic Area (EEA). It was originally intended that from the 1st April 2005, doctors wishing to practise medicine in the UK would need to hold a *licence* to practise. To retain their licence doctors would be required to satisfy the GMC, on a regular basis, that they are up to date and fit to practise. This was to be known as *revalidation* and it represents the most significant change to the regulation of the medical profession since the first register of 'qualified' doctors appeared in 1859. However, in December 2004 the UK Government announced it had decided to postpone the introduction of licensing and revalidation until a review of the 'system' had been undertaken. This is in response to the issues raised by Dame Janet Smith in the 5th report of the Shipman Inquiry. The Chief Medical Officer (England) Report 'Good Doctors, Safer Patients' was issued in July 2006. It is out to Consultation until November 2006. The UK Government will then determine the way forward for 'Medical Regulation''.

The system by which the GMC will license and validate non UK jurisdictions like ourselves and the Isle of Man etc. is likely to be achieved by working in an 'approved environment'. A GMC approved environment currently has the following characteristics;

- Appraisal is practiced to a very high standard
- There is a robust clinical governance regime
- The local governance processes are quality assured by a competent external validating agency - such as the Healthcare Commission
- Procedures exist for identifying significant concerns about a doctor's health or probity

We will ensure that our local Governance arrangements are 'fit for the purpose' of attaining local certification.

We will amend/repeal the Medical Practitioners (Registration) (Jersey) Law 1960, to ensure compliance with the new GMC process of validation and revalidation.

b) European Working Time Directives (EWTD)

The European Working Time Directive (EWTD) was introduced to the United Kingdom from August 2004. Since then there has been a phased approach to reducing all junior doctors' working hours to an average of 48 hours per week by 2009, with a maximum of 13 hours in any 24 hours, and a break of at least 11 hours before and after such a shift.

The overall implication of the EWTD is the requirement to find the most cost efficient working patterns to cover services 24/7 without compromising clinical care. It is most likely that there will be a need to further increase the number of junior doctors. Where practical, junior doctors work rotas will be changed to ensure compliance with EWTD. Resolution of this issue will be addressed as part of New Directions – the 'Sustainable Hospital' as noted earlier.

Legislation programme

Each year the department is required to propose items for the legislation programme for the proceeding year that if approved will be incorporated into the annual States Business Plan.

We shall critically assess any new proposed items of legislation and finalise a programme for the Minister of Health and Social Services. These items will be assessed and prioritised alongside all other States Departments proposals.

Risk Management

During 2007 H&SS will develop a strategy for Clinical Governance which will incorporate risk management, clinical audit and effectiveness, patient and public involvement, education, training and development, Continuous professional development and information.

The introduction of a software package last year for recording incidents claims and complaints has been developed further with the rollout of a web based reporting system. This will allow any member of HSS staff to report incidents/accidents electronically - It will also allow, subject to access, managers, teams etc to generate their own reports and corporately there is also the opportunity to identify organisation-wide themes

The benefits of this system include:

- Timely reporting and increased accuracy of reports
- An increased uptake in reporting particularly across clinical teams (as evidenced by work in the UK)
- The ability to view all incidents in a timely manner and to take appropriate action
- The introduction of a risk ranking system in preparation for the introduction of a risk register

The web based system roll out started earlier this year and has been rolled out over a phased period of time, with support in the form of training around patient safety and reporting an incident. The Clinical Risk Manager along with the Health and Safety Manager are leading on this rollout.

Over the next twelve months the rollout across H&SS will be completed and all staff with access to a networked pc will be able to input incidents in this way.

Managing Complaints

During 2007 further work will be undertake to develop a second stage for complaints – introducing an independent element to our current complaints process.

Reducing risk - Induction and Mandatory Training

In the later part of 2006 H&SS introduced a departmental induction programme for all new staff. This currently runs on a monthly basis and covers topics such as: security, risk management, data protection, infection control, health and safety - with a second day targeted at clinical staff to give them the basic mandatory training needed to reduce the risk as they enter a new clinical area, such as basic life support, manual handling, and blood transfusion.

This work will be expanded during 2007 to ensure all wards and departments compliment this day with a departmental based induction.

Following the launch of the induction day during 2007 we will be launching a monthly mandatory training update day – open to all staff working in H&SS it will cover issues such as basic fire training, basic life support, manual handling.

Clinical Audit & Effectiveness

As part of the quality improvement process two clinical auditors were appointed and commenced in post at the end of summer 2006. Over the next twelve months they will be focussing on the following key areas:-

- Developing capacity within the organisation to undertake clinical audit;
- Developing a strategy for clinical audit for H&SS as part of Clinical Governance Strategy;
- Working with clinical teams to support clinical audit in practice;
- Identification of key audits in line with H&SS priorities.

6. PUBLIC HEALTH

The Medical Officer of Health's Annual Report was published in September 2006, and made 33 recommendations which were supported in general by The Council of Ministers. The report noted that in general people in Jersey can expect to have good health. However, there are some important health challenges to meet for the future including reversing some trends in unhealthy lifestyles and improving preventative services.

Headlines from the report include:

- Smoking is public health enemy number one. The trend is downwards but smoking is still Jersey's biggest preventable cause of premature death.
- Obesity is the new public health threat for the 21st century. The upward trend in obesity among Jersey children and adults will lead to poorer health and damage to the economy if not reversed. Diabetes is the fastest-growing, life-threatening condition in Jersey. The upsurge in diabetes is linked to the 'obesity epidemic'.
- Many Islanders have chronic diseases. We need a systematic programme of health care to improve their quality of life and reduce pressure on hospital services. Developing care for chronic sufferers in Jersey, particularly in primary care, is probably the most significant health service priority for the next 10 years.
- Jersey cancer care services are praised by the patients who use them. The cancer screening services save lives. Jersey's breast and cervical screening programmes are of a high quality but are not reaching enough women. Only through creating and using a population database could we bridge this gap.
- Jersey schools are making important progress through the new healthy schools programme. I recommend that all Jersey schools join the 'Healthy Schools' Programme by 2008.
- Infectious diseases are making a come-back. A tummy bug swept through tourists in 2005. Acquired Immune Deficiency Syndrome (AIDS), Hepatitis C and sexually transmitted infections are all rising.
- We aim to reduce the upward trend in sexually transmitted infections through Chlamydia screening, developing genitourinary medicine services and through education and advice for young people.
- A world-wide flu pandemic is likely to occur during the next five to 10 years. The Island's health services have made preparations to respond.

Smoking

An example of how these concerns are being responded to is the issue of smoking related mortality and morbidity. Smoking is public health enemy number one and kills around 170 Islanders each year accounting for one fifth of all Jersey deaths. This makes smoking the biggest preventable cause of premature death and chronic disease in Jersey. 25% of Jersey adults smoke. 77% of them want to give up.

The Council of Ministers considered measures to combat smoking on 9th February 2006. Ministers discussed taking forward the Tobacco Strategy for Jersey, agreed in November 2003 by the States of Jersey. Ministers supported the strategy unanimously. On aspect of this strategy is Smoking cessation. A smoking cessation service will be offered to people who smoke to help them to give up smoking. This service will consist of tailor-made smoking cessation programmes for each individual, using advice, motivational techniques and prescribed drugs. We already experience a large number of requests for intensive, personalised smoking cessation services. We do not currently have a comprehensive service to offer them.

We plan

- An 'industrial scale' smoking cessation programme in primary care to be introduced in Jersey by the end of January 2007.
- States Departments work together to facilitate introducing this service, ensuring that funding, coordination, training, monitoring and evaluation are put in place to enable this to happen. Making nicotine replacement therapy and Zyban available through the new programme will be essential.
- 'Help to Quit - is launched with a high profile to coincide with the forthcoming smoking ban in all work places and public places.

MEDICINE

7. Pathology Services

Pathology services look at how diseases and other medical conditions affect the body. They provide information to Health staff about the likely cause of a patient's medical problem as well as advice about the effectiveness of treatment given to a patient. This is done by analysing samples taken from the body - for example, blood, skin cells or tissue and providing medical staff with a pathology report. Pathology services fall within the following major categories:

- clinical biochemistry – which examines the levels of different enzymes, hormones and other chemicals in the blood and other fluids
- haematology – which looks at the different cells in the blood, measures the coagulation factors in patient's blood and provides blood and blood products
- microbiology – which looks at disease causing micro-organisms - such as bacteria, viruses, fungi and parasites
- histopathology – which looks for signs of abnormalities (such as malignancies caused by cancer) within cell structures collected via surgical operations or other procedures

Overall, Pathology services are vital in achieving speedy and effective treatment of patients. These services must meet stringent quality assurance and legislative requirements.

Jersey Blood Transfusion Service

A small example of the issues local Pathology service face is exemplified by the local Jersey Blood Transfusion Service (JBTS).

During 1998 a general review of the local blood transfusion service was undertaken by officers of the National Blood Service (NBS). As a result, a steering group was set up to oversee the activities of the JBTS comprising local and NBS transfusion professionals with the aim of achieving Medicines Inspectorate (MCA) standards within the local transfusion service and as a consequence, compliance with the Medicines (Jersey) Law 1995. A Scientific Liaison Group (SLG) was formed to action the directives of the JBTS Steering group.

To ensure the JBTS was moving towards the MCA standards the JBTS Steering Group again invited auditors from the NBS to audit the service in 2002. They reported that unless there was investment in information technology and quality assurance we would not reach the standard required.

By 2005 it was clear that to meet increasing Quality Assurance Standards and legal requirements the JBTS was faced with 2 clear options:-

1. Supply of all blood and blood products to come from the NBS, with the loss of the locally based collection and mandatory blood release testing facilities and to pay NBS for those services or;
2. To invest to retain the use of locally collected blood and locally supplied mandatory blood release testing with computerisation and Quality Management supplied by the NBS.

A business case was prepared in 2006 to determine the best option the Pathology Service should take. The result was to choose option 2 and invest locally to maintain and enhance the Jersey Blood Transfusion Service.

SURGERY

8. Day Surgery

Day surgery is the admission of carefully selected patients to hospital for a planned surgical procedure, ideally using dedicated facilities, and the patient's return home on the same day. Treating patients on the same day is the key principle on which the concept of day surgery is based, avoiding the need for an overnight stay in hospital. Dedicated facilities enable planned treatments to be undertaken without placing pressure on inpatient beds and theatre capacity. Advantages of day surgery include:

- day surgery patients are not mixed with inpatients who are often more seriously ill;
- there is lower risk of cross infection;
- patients spend less time in hospital which they prefer;
- hospital costs are lower because day surgery is more efficient care and;
- day surgery can significantly reduce waiting times

The need for more day surgery is therefore widely recognised by patients, clinicians and managers.

The case for an extended day surgery unit was made in 2002/03 and the 'physical outcome' of that has recently been achieved. The key focus in 2007 will be on managing the expanded service and make day surgery the 'norm' for elective surgical care. In 2004 the NHS Modernisation Agency released 'Ten High Impact Changes, of which one was to maximise day surgery treatment. This included a 'basket' of 10 procedures to focus on. Of the ten procedures Jersey performs well on 6 and the expanded service will provide the capacity to enable the service to improve performance on the other 4 procedures plus day surgery care in general.

ADULT MENTAL HEALTH

9. Substance misuse

Jersey has a higher per capita rate of alcohol use than the UK by 1 ½ to 2 times, and a greater use of alcohol than France, Portugal and Spain, (Imperial College report 2001). The Imperial College report further states "… it is possible that investment may be required to also improve and expand treatment options for problematic alcohol users". The recently published shadow scrutiny report "Responding to Drug use" (October 04), recommendation 12 states, "clear partnership arrangements should be established with voluntary bodies providing proven and effective rehabilitation and after care support for substance misusers"

During 2006 Mental Health Services worked closely with Silkworth Lodge who provide a number of residential rehabilitation treatment placements for those who otherwise would not be able to afford such a service. Furthermore the Substance Misuse Joint Steering Group has been meeting regularly and is in the process of developing a care pathway for people with substance abuse problems who need residential support. An alcohol liaison nurse was appointed who works with people in the general hospital who have been identified as have alcohol problems.

During 2007 the needle exchange scheme will be developed further. This scheme provides clean needles to intravenous drug users with the aim of reducing blood born virus infections. In 2001 the number of needle sharers was 91%, since the introduction of the needle exchange scheme the number has reduced to below 50% with the most resent figure being 27%.

10. Suicide prevention strategy

The Suicide Prevention Strategy commenced in 2002 as a piece of multi-agency work looking to address the issue of suicide in Jersey. This was in response to the 2001 Annual Report of the Director of Public Health Services who first identified suicide as a local public health issue.

Jersey previously had a higher number of suicides than England and Wales. Comparison between standardized rates of suicide showed that on average England has 8.6 suicides per year per 100,000 population[1] and Jersey had 12 per 100,000 population.

The strategy has involved representatives from over 35 different departments and organisations from Health and Social Services, the States and the voluntary sector. It is an ongoing piece of work that actively seeks the involvement of a wide range of partnership organisations. Some of the organisations and departments involved to date have included the Samaritans, Community Bereavement Services, Survivors of Bereavement by Suicide, States Police, Adult Mental Health Services, Drugs and Alcohol Service, Adult Social Services, Education Welfare, Child and Adolescent Mental Health Services, Shelter Trust, Women's Refuge, Jersey Focus on Mental Health, Home Affairs, Public Services, Accident and Emergency Service and States Housing.

The following represents some of the strategy's successes:

- Developed the role of public health intelligence in strategy formation through the creation of a comprehensive profile of suicide in Jersey. This has assisted in a number of key areas including an understanding of the years of life lost through suicide, a clarification of coding practises around suicide and self-harm at the General Hospital and an audit of local prescribing practises.

- Produced and widely circulated a directory of Mental Health Services for use by those in the primary care sector.

- Devised 'mental resilience tool' which is currently being piloted as an aid for tier 1 workers who provide support for vulnerable young people.

- Produced and widely circulated leaflet containing contact details of those agencies able to provide support after a suicide. Joint working with the voluntary sector has also resulted in a higher level of inter-agency referrals after a successful suicide.

- Anti-Bullying Strategies developed in partnership with high schools.

- Young men's residential project held in partnership with Youth Service looking at ways to support young men as a high risk group in relation to suicide.

- Samaritans and Public Services working in partnership to install Samaritans contact details in car park stair wells.

- Suicide component included in Adult Mental Health Service training programme.

- Development of pathway for the police management of suicide attempts and emergency access to mental health services.

- Development of local risk assessment guidelines, which adopt a sustainable 'train the trainers' approach to be made available to a wide range of departments and organisations in 2007.

- Developed ways of ensuring that partnership agencies continued to influence and develop the strategy through annual review and development meetings.

- Ensured partnership agencies are made aware of developments through the publication of a yearly newsletter and the introduction of quarterly network meetings.

During 2007 the CAMH service will be increasing the support and training needs for those people working with young people who are at risk of self harm or suicide. The suicide prevention working party has also secured funding from The Wessex Medical Trust (HOPE) for them to carry out a local piece of research entitled "Non-Fatal self harm and suicide among psychiatric patients in Jersey".

[1] National Suicide Prevention Strategy for England, Annual Progress Report 2004.

SOCIAL SERVICES

11. Fostering and Adoption Services

Fostering & Adoption Services are a key part of the Children's Service response to providing for children in need of protection and/or accommodation under the Children's (Jersey) Law 2002 – the law imposes a statutory responsibility on the Minister to:

'Provide accommodation for any child in need who appears to it to require accommodation as a result of-

(a) there being no person who has parental responsibility for him;

(b) his being lost or having been abandoned; or

(c) the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.

These services operate alongside Residential Services whose structure and format has remained unchanged over recent times. Fostering and/or Adoption offers the best alternative, if children are unable to live with their parents, or extended family, as it provides 'family based care' and prevents children from becoming institutionalised within a large Children's Home. It also offers far greater flexibility in terms of responding to the individual needs of children or sibling groups.

The current structure has been under considerable pressure for a number of years. Several factors have contributed to this situation:

i) Constant demand in terms of the numbers of children being received into care;

ii) Increasing complexity in terms of the level of need, and the problems presented by those requiring accommodation, particularly sibling groups;

iii) A high level, proportionately, of Foster Carers 'retiring' from the service once children, placed with them for many years, have reached adulthood and the carers use the opportunity to re-evaluate their lifestyle and priorities;

iv) Increasing pressures on Foster Carers as services have responded to significant UK 'reviews'. Standards have been improved and additional demands have been placed on carers as a result – new National Minimum Standards were introduced by the UK Government in 2001 and were adopted as 'best practice' in the Island in 2002.

v) The costs associated with looking after someone else's children, in your own home, remain high and are even higher in our economy – Jersey has yet to meet the 'minimum rates' set for carers across the UK, nor pay an adjusted rate that takes into account the high cost of living in the Island.

Residential Services have also been under pressure to respond to calls for improved National Minimum Standards – staffing ratios, vulnerability of staff, targeted response to individual need and the overriding pressure to create a 'family home' within an institutional setting, have all let to demands to reduce the number of residents and increase the numbers of staff. There are very few, if any, 10/12/14 bedded units left in the UK. The average occupancy is 4-6 and the numbers of staff supporting are at, or higher, than those levels currently supporting children in the local homes.

We will develop a range of appropriate Fostering and Adoption placements, working alongside a reducing number of residential beds 'per unit'. This will provide the most appropriate mix and range of services to meet the needs of individual children or sibling groups.

12. Develop Homefinding Team and support services

The Homefinding Team provides the professional lead in the development of Fostering & Adoption Services on the Island. It is currently a very small team providing specialist services to a wide range of fostering and adoption placements as well as providing support and advice to social work colleagues, involved with care planning, which require emergency, short term or permanent placements within a family environment.

The current team, though small, is made up of highly experienced professionals with many years of practical experience in their field. Over the last five years they have provided the lead in introducing a range of developments that have moved adoption and fostering services forward to meet current 'best practice' in this area. However, pressures have impacted on the placements available such as:

- The numbers of carers have reduced considerably (from 73 in 2000 to about 30 currently) as a result of the introduction of higher standards and regular monitoring and review.
- High numbers of established carers 'retiring' as the children they have had placed with them for many years reach maturity and the carers decide that current demands, and poor allowances, mean that it is the right time to leave the service.
- The development of early intervention, comprehensive assessment and planning for 'permanence' in case management have led to the identification of placement needs at an earlier stage, with the consequence of a substantial increase in demand for long term family placements for children of all ages.

A second key issue is the 'rate of change' required. It is anticipated that demand for placements will increase, and change will be required quickly if we are to halt the diversion of resources to residential services that are, ultimately, unable to meet individual need.

We will invest in this service to expand the team so that they can lead the work of substantially increasing the rates of recruitment of new carers, in a whole new range of specialist fostering categories.

The development of the Homefinding Team is also crucial to the success of a number of other developments.

13. Crisis Intervention – Special Needs Service

The special need service is an entirely community based service, having completed the Community Living Strategy. It provides support for children and adults with some complex needs, including those people with multiple/profound disabilities and with challenging behaviour.

There is a great emphasis on enabling people to stay in their own homes, and maximise the potential of individuals to participate as citizens of Jersey. Invariably, there are times this proves to be difficult for both individuals and their family members. It is vital to provide the appropriate professional support to help manage the 'crisis' quickly and effectively, in order to enable the individual to return to or maintain their home environment long term.

When a crisis occurs it is the responsibility of the Special Needs Service to respond to this. At present there is no financial contingency to allow a proactive and planned response to these situations. Each crisis is responded to, however, on a reactive basis.

The Special Needs Service is working in partnership with the States Housing Department to develop a new build facility on the Samares site, which will provide a purpose built Intensive Support Centre, to be managed and run by the Special Needs Intensive Support Service. This will enable a unique specialist setting from which to work with individuals when they are experiencing difficulties that result in them not being able to stay at home. It is hoped that this facility will eradicate the need for hospital admission.

A business case will be developed to build in a contingency fund to enable the Special Needs service to respond proactively to any unforeseen circumstance that results in a crisis in an individuals and family life.

14. Adult Residential Care – Special Needs Service – staffing levels

Following the completion of the original Joint Secretariat for Services to People with Learning Difficulties and Their Families – ''Community Living: a strategic plan for the years 1995 to 2004'', 48 residents have been relocated from St Saviours Hospital to homes in the community.

Individuals now living in community based group homes include many with complex support needs, related to the severity of the learning disability, the level of multiple/profound physical disability, complex challenging behaviour and a dual diagnosis of mental health need. At present there are 51 people being supported in this way, across a range of 13 different settings. The units of accommodation range from one bedroom flats to group homes supporting up to 6 people.

The initial move from St Saviours was completed within the then existing ward budget allocation. No additional funding was allocated at that time. However, to ensure safe care in the community is no less

expensive than institutional care, and usually more expensive, as has proved to be the case in Jersey. Since the move to the community residential care budgets have been under considerable strain. Staffing levels to meet the needs of clients, skills mix analysis and risk assessments in key areas such as safe night cover have now been undertaken across residential services. A short fall in staffing resource has been identified in some areas relating to provision of appropriate levels of support in relation to client needs and safe management of identified risks. Funding to cover absence due to annual leave and sickness has also been identified as requiring attention.

A financial audit July 2005 identified a shortfall of 11.7fte at £371,400

A growth bid has been submitted for 2007 funding to address the most urgent budgetary pressures.

A full review of the strategy for the special needs service adult residential care is currently in progress to look at opportunities to maximise effective use of resources whilst maintaining a service which remains sensitive to individual need and choice.

15. Development of Community Care Services – Adult Social work

Large numbers of people in Jersey are living with a long-term condition and numbers are expected to rise in this group and as are those requiring more intensive community support to prevent unnecessary Hospital admissions and delays in safe discharge. Both groups are expected to increase in size in line with demographic changes and the reconfiguration of the Hospital to ensure its sustainability. Health and Social Services and its partners in social care and the voluntary sector face a challenge in reacting to and planning for this increase.

Currently, an estimated 80 per cent of costs and in the region of three quarters of Health and Social Services activity relates to the one quarter of the population with the highest need. People with longer-term health and social care needs want services that will help them maintain their independence and well-being and lead as fulfilling a life as possible.

The "*our health, our care, our say"* white paper in the UK reiterates a vision for people with longer-term needs. People want to be treated closer to home, before their condition requires an emergency admission. People want to take control of their condition, understand the warning signs and make informed choices about their care and treatment.

Promoting self-care, integrating health and social care services, moving services closer to patients and case-managing the most complex cases will improve services for people remaining longer in the community.

Service Development objectives

The objectives are to:

- reduce inappropriate admissions (bed days)
- implement new ways of working to benefit patients, staff and organisations
- reduce delays for patients
- reduce the number of professionals who add no extra value to patients' care
- improve opportunities for self-care
- contribute to the training and development of an appropriately equipped work force that is "fit for purpose."

A key issue to be addressed in the immediate future is the required rate of change for what constitutes a major piece of service reengineering in a time of resource constraints.

A growth bid has been submitted for 2007 which recognises the current pressure on the limited resources available for the commissioning and purchase of community based packages of care, however, further work will be required to analyse the potential organisational impact of these proposals as well as a full analysis of the likely costs.

As part of the New Directions project the "Community Care" sub group is currently looking at various models of provision that may provide possible developmental opportunities.

SECTION 2

2.1 SUMMARY OF KEY OBJECTIVES AND PRIORITIES

Detailed here is the summary of key objectives and priorities for the department as set out in the States Business Plan 2007/11.

AIM

To redesign the health and social care system to deliver improved health and social well being for the Island community

KEY OBJECTIVES AND PERFORMANCE/SUCCESS CRITERIA

Objective 1: Improve health and social care outcomes by reducing the incidence of mortality, disease and injury in the population.

Performance/success criteria:
By 2010:

- Increase life expectancy at birth in Jersey for men and women. (Target = for men to 78.6 AND for women to 82.5)
- Reduce mortality rates:
  - ~ From heart disease and stroke and related diseases for people under 75. (Target = 85 per 100,000 population (aged standardised mortality)).
  - ~ From cancer in people under 75. (Target = 113 per 100,000 population (aged standardised mortality)).
  - ~ From suicide and undetermined injury. (Target = 7.4 per 100,000 population (aged standardised mortality)).
- Reduce adult and children smoking rates. (Target = Adults 16+ = 24% (prevalence), Children aged 14 and 15 = 29% (prevalence) by 2006).

Strategic Plan Commitment(s): *2.1, 2.2, 2.3, 2.2.2, 2.2.4, 2.2.6 and 2.2.7*

Objective 2: Improve the consumers' experience of Health and Social Services.

Performance/success criteria:

- Secure improvements in the consumers experience of health and social services as measured by independently validated surveys. (Target = Survey scores better than England average).
- Minimise elective inpatient and outpatient waiting time. (Target = Maintain access to three months or less).
- Ambulance response times – Percentage of category A calls met within 8 minutes. (Target = 75% of calls to be responded to within 8 minutes).

Strategic Plan Commitment(s): *2.1, 2.2, 2.3, 2.3.2 and 6.2*

Objective 3: Manage staff and resources so as to improve performance and provide value for money.

Performance/success criteria:

- Financial balance achieved and, in the process, the costs of each defined service area and relevant overheads identified, so that meaningful comparisons can be made year to year and with other jurisdictions. (Target = Balanced budget (-/+ 100K).
- Minimise management costs to ensure maximum resources are directed to health and social care services. (Target = Management staff to account for less than 3% of the workforce).

Strategic Plan Commitment(s): *6.1 and 6.2*

Objective 4: To promote the independence of adults needing social care enabling them to live as safe, full and as normal a life as possible, in their own home wherever feasible.

Performance/success criteria:

- The percentage of adult social services users receiving a statement of their needs and how they will be met. (Target = 100%).
- Clients receiving a review as a percentage of those receiving a service. (Target = 70%).
- Intensive home care - Households receiving intensive home care per 1,000 population aged 65 or over. (Target = 10% or greater by 2010).
- Delayed transfer of care - The average number of delayed transfers of care per 100,000 population aged 65 or over. (Target = 30 per 100,000 population aged 65+).

Strategic Plan Commitment(s): *2.1, 3.7 and 2.1.6*

Objective 5: To maximise the social development of children within the most appropriate environment to meet their needs.

Performance/success criteria:

- Stability of placements of children looked after - The percentage of children looked after at 31 December with three or more placements during the year. (Target = 10% or less of children with 3 or more placements).
- Children in care in family placements - The proportion of children being looked after by family, friends, foster carers or placed for adoption. (Target = 80% by 2010).
- Re-registrations on the Child Protection Register - The percentage of children registered during the year on the Child Protection Register who had been previously registered. (Target = 10% or less re-registration).
- Duration on the Child Protection Register - The percentage of children de-registered who had been on the Register for longer than two years. (Target = 5% or less).

Strategic Plan Commitment(s): *3.7*

Notes:

These indicators should be used sensitively taking full account of their limitations in 'determining' the performance of health and social services; particularly, random effects or chance variation when dealing with 'small numbers' which is more prevalent for small jurisdictions such as Jersey; and the use of a small number of indicators to assesses performance from a vast array of potential clinical and non-clinical indicators.

Targets are subject to annual review and revision, and as improved data become routinely available.

2.2 KEY OBJECTIVES, PERFORMANCE INDICATORS, RISKS

References: SSP - States Strategic Plan

DIRECTORATE OF CORPORATE SERVICES

	Key Objective	Key Performance Indicators	Target	Imp Year	Key Risk	SSP Ref
1.	**Governance** Develop a second stage for complaints – introduce an independent element to our current complaints process.	Independent complaints stage in place by end of 2007.	See left.	07	Independent body unable to provide service.	2.3
2.	**Governance** Expand induction and mandatory training programme to all wards and appropriate departments.	Programmes in place	See left.	07		2.3
3.	**Ambulance Service** Review developments within primary care and plan to re-engineer our Service profile to ensure that we have the appropriate establishment and skill mix ensuring staffing levels are matched to demand. In general the review would look to – • Review skill mix – paramedics practitioner (new tier), paramedics, technicians, intermediary etc • Develop and introduce 'First Responder' scheme for Patient Transport services. • Introduce AVLS (Automatic Vehicle location System) for Control to support the above scheme. • Train PTS staff to support their front line colleagues in event of Major Incidents. • Improve response times and standards of performance - reported through the 'Balanced	Review Plan with recommendations.	Review Plan completed within 2007.	07	Failure to continuously improve the quality of our services and safeguarding high standards of care and compromising the strategic aims of the States of Jersey and Health & Social Services 'Vision for the future'.	2.3 6.2

	Score Card' approach. • Support the 'New Directions' framework for the development of H&SS models of care across the next decade. • Improve response/ability to deal with Major Incidents (CCBRN) with the introduction of a 'Emergency Preparedness Policy' fully compliant with handling Major Incidents. The plan with its recommendations would seek implementation from 2008.					
4.	**Ambulance Service** Plan for a disaster that could seriously affect the Organisation's Service delivery capability. The business continuity plan will have two components:- **Immediate Response** plan & **Business recovery** plan. Our approach to developing further the plans initiated in 2006 will be:- • **Identification** of critical business functions, resources and infrastructure; • **Assessment** of the impact of disruption on critical functions, resources and infrastructure and – • **Development** through review and testing procedures of a business continuity plan that documents procedures and information.	Revised immediate response and business recovery plan.	Revised immediate response and business recovery plan completed by end of 2007.	O	"Excused Inability" not acceptable as the public expects continuity of service. Any event that could interrupt or cause cessation of critical services will be analysed and appropriate contingency plans developed. The process will manage risks to ensure that, at all times, our Organisation can continue to operate to a predetermined level. As well as identifying critical activities under threat the Service will have assessed the resources available from both within and outside the organisation to facilitate recovery.	2.3
5.	**Ambulance Service** Review transport provision across HSS not centrally coordinated, to establish if further efficiencies can be made and to determine the future structure for non-emergency patient/client transportation as part of the	• Identified plan which outlines a strategy which prepares for an ageing population. • Improved standards of	• Plan completed by end of 2007. • Improved standards of operation and	07	Being unprepared and failing to support the strategic aims of the States of Jersey and Health & Social Services 'Vision for the future'.	2.3 6.2

	HSS Strategy for an ageing society.	operation and increased efficiency. • Introduction of revised Transport Safety Policy covering 4 main areas: - Training; Administration; Vehicle usage and Journey information.	increased efficiency as demonstrated by Ambulance Service 'balanced scorecards'. • Revised Transport Safety Policy introduced.			
6.	**CPPM** HSS will take part in a rolling program of service reviews undertaken by the Healthcare Commission to benchmark performance against all UK Trusts and declare performance in the public domain.	• Maternity Service Review • Inpatient Mental Health Service Review • Substance Misuse Service Review • Race Equality Review	Overall performance above UK average Trust.	07		2.3 6.2
7.	**CPPM** Undertake regular service user reviews to benchmark quality and standards.	Picker Institute Inpatient Satisfaction Survey.	Overall performance of how healthcare received greater than NHS England.	07		2.3
8.	**CPPM** Improve performance management reporting at a Directorate level.	Implement balanced scorecards at a Directorate level.	Directorate Scorecards providing quarterly performance information in operation by Dec 07.	07		2.3 6.2
9.	**CPPM** Deliver Quality Awards event.	Successful exhibition and awards event.	Positive media press coverage of HSS quality initiatives.	07	Not enough submitted quality improvement projects - minimum of 6 quality improvement projects required for event).	2.3

10.	**CPPM** Manage Legislation programme ensuring Laws, Regulations and Orders are approved by the States and Privy Council; and gain Council of Ministers approval for **new** items of legislation to be included in States Legislation programme.	Enactments of legalisation - new or amended - administered by the department to meet policy objectives.	See left.	07	Legislation not approved by States or Privy Council. New items of legislation not approved or deferred to 09 programme by COM.	2.4
11.	**CPPM** Establish single provider for emergency aero medical transfers to the UK.	Contractual arrangements.	Contractual arrangement in place by year end.	07		2.2 6.2

DIRECTORATE OF PUBLIC HEALTH

	Key Objective	Key performance indicators	Target	Imp Year	Key Risk	SSP Ref
1.	Lead the development and implementation of a States of Jersey Health Improvement Strategy.	• Health Improvement Strategy published, other States departments engaged. • Actions plans for priorities drawn up.	New list of health improvement targets developed.	07 07	Lack of engagement outside Public Health Department.	2.2 2.2.2 2.2.4 3.2.4
2.	Champion the introduction of a population database and screening call system.	• Population database in place. • Call system functioning for breast and cervical screening.	• Cervical screening coverage 80%. • Breast screening coverage 75%.	07	Date protection issues. States infrastructure.	2.2 2.3
3.	Develop the capacity and capability of the Public Health Department to be fit for the 21st century.	• New staffing structure in place. • All staff have appraisal & PDP. • Health Intelligence Unit fully functional.	100% of planned staffing appointed.	07	May not be able to achieve within current budget. Traditional perceptions of Public Health Department and role.	2.1 2.2 2.3
4.	Achieve fully engaged scenario for smoking.	• Smoking cessation service in place. • Smoking ban in place. • HSSD smoking policy revised. • Tobacco advertising addressed.	• Quit rates 20% at one year. • 90% compliance with law.	07 07	Perception of a few that smoking cessations is not a high priority for HSSD. States fail to endorse smoking regulations.	2.2 2.2.2
5.	Improve health behaviour for young people.	Complete a health related survey among school students in 2006 and distribute findings to schools for action by 2007.	100% of schools in Healthy Schools programme.	08	Department of Educations and/or Schools may not be fully engaged.	2.2.6
6.	Protect Islanders against significant environmental hazards.	• Waste disposal strategy health impact assessment (HIA) commissioned and completed.	Match EU directives for air quality standards.	07	Capital funding. HIA not accepted by politicians/community.	4.4 2.10

		• St Helier air quality monitoring in place. • Contaminated land strategy completed.			Reactive workloads and staffing pressures.	
7.	Reform law on nursing home regulations.	Law drafting instructions 2007. Draft Law lodged 'au greffe' in 2008. Implemented 2008.	See left.	07 08 08	Becomes more complicated than anticipated. Registration workload is high.	2.1 2.1.5 2.3
8.	Begin to tackle obesity.	• Get height and weight measurements into social survey. • Research risk factors and protective factors in Jersey. • Produce fully engaged plan.	Establish accurate baseline and set targets.	07	Funding may not be available. Culture of full engagement feels a long way off.	1.2 1.4 2.1 2.2 2.2.2 2.5 3.6
9.	Produce an annual report on the health of the population.	• Report produced and disseminated widely. • Recommendations for last year reviewed.	70% of recommendations implemented/appropriate progress.	07	Ownership of report recommendations by those who need to be involved in the implementing.	2.1 2.2 2.3
10.	Take a leading role in developing primary care and in particular governance and chronic disease management.	• Primary care vision approved by new directions. • Firsts components of delivery plan in place: • Governance unit in place. • CDM model piloted for diabetes. • Quality and Outcomes Framework/other quality assurance system in place.	See left.	07 07 07/8 08	Cooperation of GPs. Funding. Learning curve and cultural shift. IT infrastructure.	2.1 2.3 2.5

DIRECTORATE OF MEDICINE

	Key Objective	Key Performance Indicators	Target	Imp Year	Key Risk	SSP Ref
1.	Transfers of patients from Leoville / McKinstry to independent sector.	All patients transferred by end of 2007 to Independent Care Homes. SLA/Contracts in place for each home and client. Extend SLA/Contracts for other contract beds.	See left.	07	Lack of Independent Care Home capacity.	2.1 2.2
2.	Upgrade Haematology / Microbiology Quality Assurance System.	Products to meet National Blood Service requirements.	See left.	07		2.3
3.	Implement internal locum policy for medical staff.	Control rising medical locum cost and reduce agency costs.	See left.	07		6.2
4.	Appoint Consultant Paediatrician specializing in community practice.	Appoint Consultant early 2007.	See left.	07		2.2
5.	Recruit A&E Consultant to support the 'Sustainable Hospital' programme.	Recruit A&E Consultant in 2008 – Start process mid 2007 to compliment the 'Sustainable Hospital' programme.	See left.	07	Subject to approval by Senior Management Team and Royal College of Surgeons.	2.2
6.	Maintain quality and value for money Out of Hours service. (GP Coop).	Patient satisfaction.	> 75% patients very satisfied with service.	07		2.2

DIRECTORATE OF SURGERY AND ANAESTHESIA

	Key Objective	Key Performance Indicators	Target	Imp Year	Key Risk	SSP Ref
1.	Reduce outpatient waiting times to a maximum of 3 months.	Waiting times.	Reduce maximum wait for first outpatient appointment to 3 months.	O	New referrals rise at a rate greater than capacity to meet and maintain waiting time target.	2.2 6.2
2.	Maintain elective waiting times at 3 months or less.	Waiting times.	Maintain elective waiting times at 3 months or less.	07	Demand above planned capacity to meet targets.	2.2 6.2
3.	Begin operating additional day surgery theatre to meet clinical demand and an increase in the number of day case procedures.	Percentage increase in 'High Impact' day surgery marker cases.	Meet individual procedure targets.	07		2.2 6.2
4.	Expand fast track physiotherapy service to meet new demand and reduce waiting time.	Reduce waiting times and chronicity. Currently treat on average 750 patients per annum.	Reduce waiting time from 10 to 4 weeks during 2007. Treat on average 1350.	07	Demand above planned capacity to meet targets.	2.2 6.2
5.	Modernisation of hearing service - to provide digital hearing service to test/programme and fit a range of NHS/commercial aids.	New software management system in place that would also enable in the longer term improved patient outcome monitoring using electronic 'Glasgow benefit profile'.	See left – operational.	07	If not implemented continued 'outdated' hearing service.	2.2 2.3
6.	Appoint 3rd Orthopaedic surgeon as part of Medical Manpower plan.	Elective waiting times. Outpatient waiting times.	Maintain waiting times at maximum of 3 months Reduce outpatient waiting time to 12 weeks.	07	Demand above planned capacity to meet targets.	2.2 6.2

7.	Development of pain clinic services to meet demand, improve efficiency and improve patient outcomes – provide co-ordinated 'Return to Work' initiative for chronic pain sufferers.	Waiting times.	Reduce maximum wait for first outpatient appointment to 3 months.	07		2.2 6.2
8.	Reconfigure surgical beds to support the forthcoming Clinical Decisions Unit.	Reconfigured surgical beds.	See left.	07		2.2
9.	Establish low vision and rehabilitation service.	Establish service and provide to circa 200 patients per annum.	April 2007	07		2.1 2.3

DIRECTORATE OF ADULT MENTAL HEALTH

	Key Objective	Key Performance Indicators	Target	Imp Year	Key Risk	SSP Ref
1.	By 2008 develop care pathways for young people with mental health problems who require care and support in the community or hospital admission.	Care Pathways in place by 2008.	Relevant agencies will be aware of and using the care pathways.	O	Lack of primary mental health care workers to implement the care pathways. Excessive workload of single-handed consultant.	2.3
2.	Introduce the electronic mental health record system to the Old Age Psychiatry service - (FACE).	FACE implemented by 2007.	See Left.	07	ICT training for all staff. Lack of funding for FACE licence.	2.3
3.	Assist FOCUS residential care programme to support people with longer term mental health problems to live in the community – 17 clients.	Provide funding for FOCUS residential care programme – £70K. Completion of Service Level Agreement.	See left.	07		2.3
4.	Commence the implementation of the prison health care needs (Wool report) in 2007.	Commence 'Wool' Report recommendations such as - • All female prisoners will have a psychiatric assessment. • Social work assessment will be available to prisoners. • Introduction of 'healthy prisons' initiative.	All secondary health care to the prison will be provided through HSS.	07		2.3
5.	Introduce training for 'family work' for mental health professionals.	All clients with a first diagnosis of serious mental illness will have access to family work - working with the families of people with schizophrenia etc. in how best to	• 6 staff trained in family work. • 48% of families receiving family interventions with	07	Training time to cascade skills and knowledge.	2.3

		support the recovery of the sufferer.	enduring mental health problems.			
6.	Introduce full paraphernalia for the needle exchange scheme - All fit-packs will contain full paraphernalia for injecting drug users reducing the spread of blood born viruses.	• Harm reduction from needle sharing i.e. skin damage. • Reduce levels of blood virus through needle sharing.	• Harm reduction from needle sharing. • Reduce levels of blood virus through needle sharing.	07	No funding from HSS. To work with BaSS to identify possible funding for 2007 from current underspend with a commitment from HS to fully fund from 2008	2.2 2.3
7.	Implement service user involvement within the mental health directorate.	• Appointment of service user co-ordinator. • Strategic involvement of service users. • Service user led self-help programmes. • Service user council.	• Appointment of service user co-ordinator by 2007. • Strategic involvement of service users e.g. Steering Group members. • Service user led self-help programmes supported by HSS/FOCUS e.g. Training skills enhancement. • Service user council established by 2008.	07	Change in the philosophy of care provision may challenge professionals. Funding for implementation will need to be established.	2.2 2.3

DIRECTORATE OF SOCIAL SERVICES

	Key Objective	Key Performance Indicators	Target	Imp Year	Key Risk	SSP Ref
1.	Implement and continually monitor a substantial three-year programme of investment by early 2006 to increase the number of foster carers through improved recruitment, training and financial support.	Additional 'sets' of mainstream and professional Foster Carers. Mainstream Professional (Currently 30 'sets' of foster carers offering 40-45 placements).	 20 12.	O	Inability to recruit sufficient sets of foster cares.	3.7
2.	Ensure Adult Social Services clients receive a statement of their needs and how they will be met.	The percentage of adult social services users receiving a statement of their needs and how they will be met.	100%	O	Currently there 1.3 qualified adult social workers per 10,000 population aged 18+ compared to an English Authorities average of 5.2 per 10,000 population aged 18+. This may affect the ability of the service to reach/maintain the target.	3.7
3.	Ensure Adult Social Services clients receiving a service receive a review of their care annually.	The percentage of clients receiving a review as a percentage of those receiving a service.	70%.	O	As stated above, this improvement is despite the low level of Adult Social Work staff for the size of the local population.	3.7
4.	Improve on the proportion of children being looked after by family, friends, foster carers or placed for adoption.	The proportion of children being looked after by family, friends, foster carers or placed for adoption.	80% by 2010.	O	Local circumstances mean that we are not able to provide the 'range of options' open to a UK Local Authority – private fostering agencies, inter-county placements and private residential care providers. Thus It may prove difficult to attain this target.	3.7
5.	Review, clarify and state the core role and responsibilities of the Special Needs Service to ensure robust, sustainable services which meet individual needs.	• Contribute to the review of SNS led currently in progress supported by the Jersey Joint Secretariat for People with a learning disability. • Complete comprehensive nursing	See left.	07	Failure at service and strategic level to recognise and respond to the key factors that increase both pressure and risk in a fully community based service for individuals with complex support needs. Failure to establish clear action plans and appropriate strategic growth bids to support the	3.7

		care review of the adult residential services, in response to the current pressures regarding key risks and minimum standards of care.			continued developments of service provision.	
6.	Development of Community Care services.	• Reduction in delayed discharges	See left.	07/08	Failure to engage and work with key partner agencies and the voluntary sector. Lack of resources. Inflexible service providers	3.7

SECTION 3 - RESOURCES FOR 2007/09

3.1 REVENUE CASH LIMITS 2007/09

	2007 £'000	2008 £'000	2009 £'000
Base Budget b/fwd	132,469.4	137,094.5	143,329.8
Departmental transfers	(1,102.2)	-	-
Resource Allocation Process	3,272.9	3,354.7	2,000.00
Strategic Plan funding	-	-	-
Efficiency savings	(948.5)	(639.4)	(114.1)
Pay awards	2,749.3	2,849.3	2,911.4
Non-staff inflation	653.6	670.7	690.3
Other adjustments	-	-	-
Cash Limit	**137,094.5**	**143,329.8**	**148,817.4**
Variation (%)	3.5%	4.5%	3.8%
Manpower Costs (£'000)	105,366	110,015	114,176
Manpower Numbers (FTE)	2,212.50	2,272.50	2,332.50

3.2 INVESTMENT PROGRAMME

As cited earlier the 2007 cash limit provides growth of £3.3 million, equating to 2.5% growth on the 2006 cash limit whilst also requiring efficiency savings of £0.9 million. Thus a major issue facing the Department is how to allocate the limited resources made available and reconcile this level of funding with ever increasing demands on the service.

The Departments real revenue growth for 2007 is £3,272,900.

The investments detailed below were carefully evaluated and prioritised against the Departments stated aims.

The investments will be phased throughout the year to remain within the revenue growth limit of £3,272,900.

Description	2007 Full Year Cost
Dedicated complaints manager	55,000
Cadet Nurse Scheme	104,500
Family based care	330,000
Care packages	78,760
Family Support Workers Pay Review	56,010
Establish clinical involvement in management structure	80,000
Healthcare Commission Inspection/Reviews	150,000

Funding residential care	200,000
Funding UK placements	100,000
Tobacco control officer and out of hours support	51,500
Pneumococcal and New Hib/Men C Vaccine	141,600
Smoking cessation programme	450,000
Anaesthetics Staff Grade	55,000
Medical Defence Union Insurance	170,000
Revenue for new Day Surgery Unit	814,000
Breast Screening programme	52,100
Fast Track Physiotherapy service	71,800
Ear Nose and Throat Staff Grade	65,000
2 additional oral surgery sessions	19,000
3 additional orthodontic sessions	61,920
3rd Orthopaedic consultant	358,900
Modernisation of hearing aid service	83,000
3 additional sessions for dental consultant	66,300
Physiotherapy support for expanded DSU and 3rd Orthopaedic Consultant	100,700
Expansion of pain clinic service	394,840
Additional appointments staff	84,720
General Practitioner Co-op	86,100
Haematology / microbiology upgrade of Quality Assurance System	250,000
Additional oncology nursing staff	43,700
7th Directorate of Medicine Registrar	80,280
Rheumatology drugs	125,000
Plasma reduction	107,000
Referral of HER2 testing to Uk and prescription of herceptin	57,000

Adult Learning Disability Residential Services	210,960
Community based low vision services	84,400
Prison healthcare	190,000
Jersey Focus on MH	70,000
School vision screening	63,800
Low vision aids	20,000
Associate specialist in diagnostic and therapeutic haematology	63,000
Total	**5,645,890**

NB: Figures rounded

3.3 CAPITAL PROGRAMME

Capital Programme 2007 to 2009

2007	£
ICT Strategy	4,000,000
Minor Capital Allocation	1,800,000
Total	**5,800,000**

2008	£
A&E / Radiology Extension (Phase 2)	2,523,000
Tube System Upgrade	654,000
General Hospital Upgrade (Phase 2)	1,189,000
Central Laundry Batch Washer	500,000
ICT Strategy	3,000,000
Minor Capital Allocation	1,800,000
Total	**9,666,000**

2009	£
ICT Strategy	3,000,000
Minor Capital Allocation	1,800,000
Total	**9,358,000**

3.4 NET EXPENDITURE – SERVICE ANALYSIS 2007

Net Expenditure – Service Analysis

2005 Actual £	2006 Estimate £		2007 Estimate £
		Public Health Services	
723,666	788,500	Public Health Medicine	904,400
579,598	958,300	Clinical Public Health Services	884,800
931,379	781,400	Health Protection	901,600
538,907	570,100	Health Improvement	586,800
		Medical Services	
6,142,914	5,084,100	Medical Specialties	5,290,300
2,731,894	2,588,300	Paediatrics	2,661,200
1,747,481	1,669,800	Renal Services	1,686,100
1,667,081	1,407,600	Outpatient Services	1,460,100
7,013,325	7,073,100	Medical Wards	7,159,700
3,068,660	3,278,800	Accident and Emergency	3,287,000
5,481,706	5,082,700	Assessment and Rehabilitation for Older People	5,298,700
10,567,653	11,007,100	Continuing Care for Older People	11,412,800
6,393,379	6,838,100	Pathology	7,116,000
1,994,978	1,745,200	Pharmacy	1,883,800
3,205,446	4,063,500	Therapy Services	4,091,000
		Surgical Services	
13,285,661	13,093,600	Surgical Specialties	13,311,900
4,282,792	4,268,900	Obstetrics and Neo Natology	4,452,100
5,664,161	5,836,600	Theatres	5,928,700
9,070,940	9,335,700	Surgical Wards	9,397,500
(93,377)	(418,700)	Private Patients Wards	(355,900)
2,345,812	2,844,700	Physiotherapy	2,869,000
2,009,136	2,602,700	Radiology and Diagnostic Imaging	2,737,700
		Mental Health Services	
643,296	980,400	Alcohol and Drugs Service	1,288,900
8,875,978	9,140,700	Adult Mental Health Services	9,220,800
903,432	913,000	Child and Adolescent Mental Health Services	956,100
7,061,948	6,665,500	Elderly Mentally Illness Services	6,761,400
		Social Services	
6,562,211	6,324,600	Childrens Services	8,169,300
2,963,750	4,312,000	Adult Social Services	3,701,600
6,837,374	8,477,600	Special Needs Service	8,859,400
		Ambulance Services	
3,692,806	4,491,900	Ambulance	4,522,700
599,024	663,600	Patient Transport	682,400
£ 127,493,011	**£ 132,469,400**	**Net Revenue Expenditure**	**£ 137,127,900**
-	-	Allocation of Additional Funding for the Comptroller and Auditor General	(33,400)
£ 127,493,011	**£ 132,469,400**		**£ 137,094,500**

Health and Social Services is restructuring the management of its services during 2006, as a result comparison of services between years may be difficult.

Note: The Council of Ministers received an additional funding request from the Comptroller and Auditor General for £109,000. The Council of Ministers agreed the request, but were not prepared to increase total expenditure, and consequently have agreed a pro-rata reduction in all Ministerial departments' cash limits.

3.5 SERVICE ANALYSIS – OBJECTIVES AND PERFORMANCE MEASURES

Service	Objectives	Performance Measures
Public Health Services, comprising: public health medicine, health intelligence, health protection and health promotion. £3,277,600 51.0 FTE	To Improve health and social care outcomes by reducing the incidence of mortality, disease and injury in the population.	1. Increase life expectancy at birth in Jersey for men and women. 2. Reduce mortality rates: - from heart disease and stroke and related diseases for people under 75; - from cancer in people under 75. 3. Reduce adult and children smoking rates.
Medical Services, comprising: medical specialties, paediatrics, renal services, outpatient services, medical wards, accident and emergency, assessment and rehabilitation for older people, continuing care for older people, pathology, pharmacy. £51,346,700 723.0 FTE	To provide prompt diagnosis, effective treatment and rehabilitation for medical patients.	1. Minimise elective inpatient and outpatient waiting time. 2. Minimise delayed transfer of care.
Surgical Services, comprising: surgical specialties, obstetrics and neonatology, theatres, surgical wards, private patients wards, physiotherapy, radiology and diagnostic imaging. £38,341,000 639.0 FTE	To provide prompt diagnosis, effective treatment and rehabilitation for surgical patients.	1. Minimise elective inpatient and outpatient waiting time. 2. Increased day case rates against 'basket' of NHS procedures.
Mental Health Services, comprising: alcohol and drugs service, adult mental health services, child and adolescent mental health services. £18,227,200 337.0 FTE	To provide accessible and high quality services, based in the community whenever possible; and ensuring quality inpatient treatment and continuing care facilities for patients who require it.	1. Maintain progress in reducing occupied bed days for working age adults with mental health problems. 2. Tertiary referrals will be assessed within 28 days. 3. Reduce mortality rate from suicide.

Service	Objectives	Performance Measures
Social Services, comprising: childrens services, adult social services, special needs service. £20,730,300 386.0 FTE	To promote the independence of adults needing social care enabling them to live as safe, full and as normal a life as possible, in their own home wherever feasible. To maximise the social development of children within the most appropriate environment to meet their needs.	1. The percentage of adult social services users receiving a statement of their needs and how they will be met. 2. Clients receiving a review as a percentage of those receiving a service. 3. Stability of placements of children looked after. 4. Children in care in family placements. 5. Re-registrations on the child protection register. 6. Duration on the child protection register.
Ambulance Services, comprising: emergency ambulance services and patient transport. £5,205,100 75.0 FTE	To provide an Ambulance Service and related activities that are recognised as being in the best interest of the patients and community we serve.	Percentage of category A calls met within 8 minutes.

3.6 SUMMARY OF EFFICIENCY SAVINGS IN CASH LIMITS

	2007 £'000	2008 £'000	2009 £'000	Total £'000
Departmental Efficiencies	446.9	247.6	114.1	**808.6**
Corporate Efficiencies				
- Human Resources				**-**
- ICT	97.2			**97.2**
- Finance	30.0			**30.0**
- Property	- 32.9			**- 32.9**
- Procurement	235.7	220.2		**455.9**
- Other	171.6	171.6		**343.2**
	501.6	391.8	-	**893.4**
Total Efficiency Savings	948.5	639.4	114.1	**1,702.0**

This analysis shows the latest profile of efficiency savings based on the allocations used in preparation of the Annual Business Plan 2007.

3.7 STATEMENT OF SUPPORT SERVICE COSTS

Support Service	Direct Expenditure (£'000)	Total Income (£'000)	Net Expenditure (£'000)	Total FTE's	Basis of Allocation
Service Management	498	0	498	5.7	Budget
Finance	1,146	-47	1,100	15.0	Budget
IT	898	-9	888	8.0	Budget
HR	204	0	204	0.0	No of staff
Training	1,154	-73	1,081	14.5	No of staff
Property & Engineering Services	7,530	-1,313	6,217	94.9	No of staff
Ambulance Control	694	0	694	13.8	Budget
Catering	2,948	-1,054	1,894	44.5	No of Staff
Hotel Services	8,104	-29	8,075	257.2	No of Staff
Medical Records	620	-1	618	21.7	No of Staff
Clinical Governance	586	-19	567	11.4	No of Staff
	24,381	(2,545)	21,836	486.8	

SECTION 4

4.1 – GLOSSARY

Ambulance paramedics	Emergency Ambulance crew members who have received specialised training in emergency life-support and similar interventions.
Care pathways	An agreed set of procedures or treatments for a specific disease condition or type of patient, involving health and social care professionals in primary, secondary and tertiary care, to ensure the continuity of care (or 'seamless' care).
Client-centred care	Care services which are configured to meet the needs of clients in they way that is most acceptable to them, and wherever possible puts their preferences above those of the organisation.
Clinical audit	A systematic approach to evaluating treatment or care, compared against agreed standards and procedures, with the aim of improving quality and clinical outcomes.
Clinical guidelines	Authoritative advice on cost-effective treatments or other interventions for specific conditions or types of patients, based on the best available evidence.
Clinical (sub-) specialisation	The shift towards new and more highly skilled health care, requiring special training or equipment, which involves an increasing number of individuals to provide the range of techniques. The generalist or 'Jack of all trades' clinician no longer exists in secondary health care.
Critical mass	The minimum level of activity, number of staff or size of facility that is required to ensure an adequate level of expertise to maintain good clinical standards or sufficient number of patients to justify the continued operation of the service.
DATIX	This is healthcare risk management software that enables the Department to create a comprehensive picture of the organisation's risks by integrating information from patient and staff safety incidents with complaints, claims and health and safety incidents that affect staff and visitors as well as patients. A Risk Register and Assurance Framework allow these risks to be prioritised and assure that the Departments principal risks are adequately controlled.
European Working Time Directive	This is a directive of the Council of the European Union (93/104/EC) which laid down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. This formed part of the Social Charter and was intended to protect the health and safety of workers in the European Union. The Directive was enacted in UK law as the Working Time Regulations which took effect from the 1st October 1998.
Evidence-based practice	The use of current best practice, based on systematic review of all available evidence, in making and carrying out decisions about the care of individual patients.
General Medical Council (GMC)	The United Kingdom professional regulatory body for medical practitioners, accountable to the United Kingdom government for maintaining the standards of medical practice, professional conduct and performance.
Governance	A system of accountability and a comprehensive framework within which health care organisations continuously improve the quality of their services and safeguard high standards of care.
Integrated health and social care	An initiative to ensure improved co-ordination of primary, secondary and community health and social care.
National Service Frameworks	National Service Frameworks help establish clear national standards for services to improve quality and reduce unacceptable variations in standards of care and treatment.
National Institute for Clinical Excellence (NICE)	NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.
Royal Colleges	The specialist professional bodies for health practitioners - establishing the educational and competence standards for professionals.

Performance framework / Performance indicators	A systematic methodology and criteria for monitoring and evaluating the effectiveness and achievements of the strategy.