Health and Community Services

Health and Community Services Department Advisory Board

Wednesday 4th October 2023

Meeting Papers

AGENDA

MEETING: Part A - Health and Community Services Advisory Board
DATE: Wednesday 4th October 2023
TIME: 9:30am – 5:00pm
VENUE: Main Hall, St Paul's Centre, Dumaresq Street. St Helier. Jersey JE2 3RL

	Description	Owner	Time
OPENING ITEMS			
1	Welcome and Apologies	Chair	**9:30am**
2	Meeting in Public - Conduct		
3	Declarations of Interest	Chair	
4	Minutes of the Last Meeting	Chair	
5	Matters Arising and Action Tracker	Chair	
6	Chair's Introductions	Chair	
7	Chief Officer's Report	Chief Officer	
QUALITY AND PERFORMANCE			
8	Quality and Performance Report Month 8	Director of Clinical Service, Director of Mental Health Services and Adult Social Care, Medical Director and Chief Nurse	**10:15am** (45 mins)
9	Finance Report Month 8	Chris Bown / Obi Hasan	**11:00** (10 mins)
10	Workforce Report Month 8	Chris Bown / Steve Graham	**11:10** (10 mins)
11	Serious Incidents Position Statement	Patrick Armstrong	**11:20** (10 mins)
12	Complaints Position Statement	Jessie Marshall	**11:30** (10 mins)
13	Waiting List Report (including diagnostics).	Claire Thompson	**11:40** (10 mins)
14	General Surgical Acute Rota - Verbal	Patrick Armstrong	**11:50** (10 mins)
15	Job Planning	Patrick Armstrong	**12:00** (10 mins)
16	National Institute for Health and Care Excellence (NICE) / Royal College Guidelines	Patrick Armstrong	**12:10** (10 mins)
17	Acute Medicine		**12:20** (10 mins)
18	Maternity Improvement Plan (MIP) Workstreams	Claire Thompson	**12:30** (10 mins)
19	Infection Prevention and Control (IPAC) Audit Improvement Work	Patrick Armstrong / Jessie Marshall	**12:40** (10 mins)

20	Appraisal and Revalidation for Doctors – Position Statement	Patrick Armstrong	**12:50** (10 mins)
CULTURE			
21	Cultural Change Programme	Chris Bown / Cheryl Power	**13:00** (10 mins)
22	Incidents of Racial Abuse – Management of	Chris Bown / Cheryl Power / Steve Graham	**13:10** (10 mins)
23	Update on the 61 recommendations from the Review of Governance Arrangements within Secondary Care	Anuschka Muller	**13:20** (10 mins)
GOVERNANCE			
24	Mental Health and Capacity Legislation – Report from the Multi Agency Assurance Group	Andy Weir	**13:40** (10 mins)
25	Policy Documents / Procedural Guidelines – Management of	Jessie Marshall / Patrick Armstrong / Andy Weir	**13:50** (10 mins)
26	Overdue Risks	Patrick Armstrong	**14:00** (10 mins)
27	Statutory and Mandatory Training Needs Analysis	Andy Weir / Jessie Marshall	**14:10** (10 mins)
28	Consultant Appointments	Chris Bown	**14:20** (10 mins)
INFORMATION			
29	Estates Report	Claire Thompson / Jon Carter	**14:30** (10 mins)
PRE-SUBMITTED QUESTIONS FROM THE PUBLIC			**15mins**
	MEETING CLOSE Date of next meeting: 1st November 2023		**14:55**

Health and Community Services Advisory (Shadow) Board

Health and Community Services

Date: 10 July 2023	Time: 2:30 – 5:00pm	Venue: PCH 3rd Floor West Wing Board Room

Attendees:		
Professor Hugo Mascie-Taylor - **CHAIR**	Fixed-term Chair of the Board	**HMT**
Christopher Bown	Chief Officer HCS (Items 1-7 only)	**CB**
Andy Weir	Director of Mental Health Services and Adult Social Care	**AW**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Jessie Marshall	(Acting) Chief Nurse	**JM**
Claire Thompson	Director of Clinical Services	**CT**
Dr Adrian Noon	Chief of Service Medicine deputising for Patrick Armstrong, Medical Director	**AN**
Dr Cheryl Power	Director of Culture, Engagement and Wellbeing	**CP**
Steve Graham	Associate Director of People HCS	**SG**
Professor Simon MacKenzie	Medical Lead – HCS Change Team	**SMK**
Obi Hassan	Finance Lead – HCS Change Team (items 1-8 only)	**OH**
Beverley Edgar	Workforce / Organisational Development Lead – HCS Change Team	**BE**
Emma O'Connor	Board Secretary	**EOC**
Lauren Ferguson	PA Support to the MHSS (observing)	**LF**
Ashling McNevin	Freedom to Speak Up Guardian (FTSU) Item 19 only	**AMN**
Ross Barnes	Head of Non-Clinical Support Services (Part B, Item 3 only)	**RB**
Washington Gwatidzo	REACH Representative (Item 20 only)	**WG**

PART A

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

HMT welcomed all to the meeting. Noting the length of the agenda and the collective previous experience of Board meetings, it was agreed that future meetings of the Board would take place over a whole day.

Apologies received from:

Patrick Armstrong	Medical Director	PA
Michelle West	Transition Director	MW
Cathy Stone	Nursing Lead – HCS Change Team	CS
Obi Hassan	Finance Lead – HCS Change Team (*Leaving at 3:30pm)*	OH

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

No declarations.

3	Minutes of the Previous Meeting	Action
The minutes of the meeting held on 31st May 2023 were agreed.		

4	Matters Arising / Action Tracker (incl. Matters Referred)	Action
ACTION 21: Cultural Change Programme paper submitted and on the agenda for this afternoon's meeting (item 15). Agree **CLOSE**.		
ACTION 20: Recruitment activity and transformation is included within the work force report which is item 14 on this afternoon's agenda. Agree **CLOSE**.		
ACTION 19: Estates report will be included in the Sept Board paper following presentation of the quarterly report to the assurance committees in July. Remain **OPEN**.		
ACTION 18: Freedom to Speak Up (FTSU) report has been submitted and is on this afternoon's agenda (items 19). Agree **CLOSE**.		
ACTION 17: Not due until November 2023 meeting. Remain **OPEN**.		
ACTION 16: ADHD waiting times have been addressed within the Activity, Finance and Workforce Report (Item 12 on this afternoon's agenda). Agree **CLOSE**.		
ACTION 15: Not due until Oct 2023.Remian **OPEN**.		
ACTION 14: Update report on this afternoon's agenda, item 16. Agree **CLOSE**.		
ACTION 13: Not due until Sept 2023. Remain **OPEN**.		
ACTION 12: Not due until Sept 2023. Remain **OPEN**		
ACTION 11: A paper has been submitted and is on this afternoon's agenda (item 9), however, it does not address the action, i.e., the improvement work undertaken and outcomes of this regarding hand hygiene compliance.		
ACTION: HMT requested resubmission of the paper for the next meeting to include the above and to be explicit as to whether individuals are following the hand hygiene policy and if not, what action is being taken.		PA / JM
Noting the recommendations in the paper, HMT sought to establish if mandatory training exists in this area. A policy has been approved that details the approach to mandatory training, however, there is no agreed position as to what mandatory training is. This piece of work is expected to be completed by September 2023. CB asked what the challenges are to completing this work before September 2023 – AW explained this is due to the non-alignment of the Government of Jersey (GOJ) Corporate Induction requirements and HCS's requirements which is currently resulting in duplication.		
ACTION: HMT to write to Mark Grimley (Group Director People and Corporate Services) with recommendation (to align mandatory training requirements) for presentation to the States employment Board.		HMT
ACTION: Training (mandatory) needs analysis will be presented to the Board in October 2023.		AW / JM
ACTION 10: Not due until Sept 2023. Remain **OPEN.**		

ACTION 9: Update report has been submitted for discussion this afternoon (item 8). Agree **CLOSE.** **ACTION 8:** Postponed until Sept meeting due to leave. Remain **OPEN.** **ACTION 7**: Paper has been submitted for discussion this afternoon (item 10). Agree **CLOSE.** **ACTION 6:** Deferred until the next meeting as the Programme Board for the EPR has only recently held its first meeting. Remain **OPEN**. **ACTION 5:** Included within activity & performance report (item 12). Agree **CLOSE.** **ACTION 4:** Paper has been submitted for discussion at this afternoon's meeting (item 11). Agree **CLOSE**. **ACTION 3**: The MHSS has agreed that the frequency of the assurance committees can be reduced to bimonthly, chaired by HMT in the short term. Agree **CLOSE**. **ACTION 2**: Noted that the approval route for terms of reference (ToR) for assurance committees is addressed in the Board ToR and there is also a requirement to establish a Risk and Audit Committee. ACTION: To review the function of the HCS Risk Management Committee (RMC) and the approach HCS would like to take regarding management of risk. **ACTION 1:** Ongoing. However, as per previous discussion at Item1, the meetings will be held over a whole day. Remain **OPEN.**	EOC, AW, SMK, AM

5	**Chair's Introduction**	**Action**
Recruitment of Non-Executive Directors (NEDs) The recruitment process for Non-Executive Directors (NED) continues although the Chair will not be involved. The Public Accounts Committee (PAC) are aware of this. Public Accounts Committee (PAC) A PAC hearing was held this morning which included questions focussed on the process of objective setting, processes of Connect system and suitability for healthcare, finance, change team, recruitment, centralisation of supporting services, Team Jersey.		

6	**Chief Officer (HCS) Report**	**Action**
CB took the paper as read. In addition, • The MHSS will be attending a two-day workshop with the Council of Ministers (CoM) to discuss the Government Plan 2024. • CB noted a correction to 2.k – the reference to a change in the tax law is incorrect, rather it is the enforcement of existing revenue law. • The Nursing and Midwifery Council (NMC) review of education provision within General Nursing, Mental Health and Midwifery resulted in full endorsement. • There is a need to produce a high-level workforce plan by September 2023 which feeds into the business case as part of the New Healthcare Facilities (NHF) work.		

HMT asked CB to advise those staff mentioned in section 4: Highlight of Staff Achievements, the Board noted these achievements. The Board confirmed it is fully supportive of the enforcement of existing tax law and support the application of premiums to attract staff if necessary.	

7	**Quality and Performance (QPR) Report** – Month 5	**Action**
Paper taken as read.		

8	**Quality and Risk Committee Report**	**Action**
JMa took the paper as read and verbally summarised some key points, • A reduction in the number of hospital acquired pressure ulcers continues. • The number of falls remain low with 6.2 patients per 1000 occupied bed days. All falls reported resulted in either low or no harm. • HCS overdue risk is at its lowest level since monitoring began. • At the end of May 2023, 94 complaints remain open, with 10 complaints remaining open for greater than six months. To-date, this has reduced to 76 outstanding complaints. • There are 327 policy documents that are more than three years overdue, and 222 documents that are more than five years overdue. A Policy Manager post has been created and recently recruited to oversee policy work. • A new Serious Incident (SI) process has been put into place to ensure that patient safety remains paramount. To-date, all current SIs have investigators assigned which is a significant improvement. ACTION: A report at each meeting of the Board detailing current SI and Complaints position. In response to HMT's comment regarding the number of policy documents for an organisation of this size, AW advised that there is a need to differentiate between policies (clinical and corporate), documents and patient leaflets. SMK noted that these are not all clinical policies although cautioned against underestimating the size of the issue as there may be gaps in existing policy. HMT echoed that the Board must be made aware of how many of the overdue policy documents are clinical policies and secondly, the process to resolve this (including Board assurance of effective oversight). HMT suggested that many clinical policies and guidelines will already exist, and a decision can be made to adopt these, rather than unnecessarily reinvent policy (similar to the SLT decision to adopt NICE guidance). However, there must be a robust process in place where a decision is made not to adopt an existing policy, signed off by an Executive Director. ACTION: SMK and CS to support PA and JMa in progressing the policy review (due Oct 2023). Report to the Board in October 2023 must include the number of overdue policies, specifically clinical policies.	PA, JMa PA, JMa

9	**Infection Prevention and Control (IPaC) Audit Improvement Work**	**Action**
Discussed under agenda item 4, action 11.		

10	Royal College of Physicians (RCP) Review of Acute Medicine – HCS Improvement Plan	Action
AN present and paper taken as read. The report has been shared extensively with staff and several meetings have been held with Consultants. There is broad agreement that change is required, and this must be delivered. Some of the change required is already being delivered through other programmes such as the Recognition, Escalate and Rescue (RER) Programme and #BeOurBest; this will be mapped against this improvement plan. Where there are existing resources, names have been assigned to actions. However, additional resources will be required to project plan and to deliver some of the actions. AN suggested that progress is reported regularly to the Board. Following a private briefing from SMK and CS to HMT regarding acute medicine and maternity services, HMT has asked CB to lead the relevant Executive Directors (with the support of the Change Team) to produce a summary of the current position within both these services and improvement plan work. An extraordinary meeting of the (Shadow) Board will be convened at end-August 2023 specifically for these two items. If these areas are believed to be the areas of highest risk, regular progress updates of improvement work must be discussed at the Board. ACTION: An extraordinary meeting of the Board to be convened at the end-August 2023 to discuss Acute Medicine and Maternity services. ACTION: Relevant Executive Directors (with the support of the Change Team) to produce a paper for Acute Medicine and Maternity services detailing, • An assessment of the quality of the services now (referencing external reviews), • a summary of actions already taken, • a clear vision of what a future service looks like including how and when this will be achieved. CB in agreement but noted that additional resource may be required, particularly to support Medicine (taking account of the Rheumatology review already taking place in Medicine). General discussion followed regarding the need for the development of a Clinical Strategy to direct the services which HCS will / can provide and following this, the resources required to deliver these services safely. It was acknowledged that choices may then have to be made, depending upon resource availability as to which services can continue.		HMT CT, PA, JMa, SMK, CS

11	NICE Guidelines	Action
The Board declared its support for the decision to adopt NICE and Royal College guidance as the basis for HCS practice. ACTION: Broad dissemination through the line management structure.		All Exec

12	Activity and Performance (General Services / Mental Health Services and Adult Social Care)	Action

Paper taken as read.	

13	Finance Report – Month 5	Action

OH guided the Board through a series of slides. Key points,

- Year-to-date overspend of £12.5 million which is a significant adverse movement over one month (mainly due to catch up costs). Due to a lack of confidence in the current finance systems, it is too early to say that there will be no further adverse variance. However, these are being worked through as some of the issues are recognised in reporting tools.
- The main drivers of the overspend remain unchanged, including vacancies. As of May 2023, there are 499 vacancies, of which 182 are covered by agency staff.
- Non-pay drivers include all the tertiary care contracts and care packages in Mental Health and Adult Social Care. The 30 highest value contracts will be reviewed a part of the Financial Recovery Programme (FRP).
- Underachievement of income which is mainly due to unavailability of surgical beds.
- This YTD position translates to a full year forecast of £21.3 million overspend. If some of the impacts of the recovery work do not materialise between now and December 2023, the downside scenario is likely to be a £26 million overspend.

Referring to Slide 5 and the YTD overspend of £0.7million, HMT asked if increasing productivity is a solution. CB noted that improved productivity means that the same can be achieved with less staff i.e., less agency / locum, and also income can be generated by freeing up beds and theatre capacity.

Referring to slide 7 and *£13.9 million impact of baseline budget pressure (negative budget),* HMT sought to clarify whether this is funding that HCS is not currently receiving. OH explained that following the budget setting exercise for 2023 (took place in Dec 2022), the overspend pressure was noted to be £19.8million, reduced to £13 million. This was the deficit position that Treasury funded following HCS's declaration. The question is whether the underfunding is concerned with structural factors or productivity. If it is a structural deficit, then this needs to be funded. If funding is not available, then the question is whether HCS can continue to provide current services.

The growth underspend is approximately £2.5 million and the COVID reserves underspend is approximately £2million. Treasury permission would be required to repurpose this money to mitigate the year-end position.

HMT asked OH how the Board could act to best effect. OH explained that,

1. Regarding pay, recruitment and retention is key.
2. Regarding non-pay, establishing a PMO to review the highest value tertiary contracts.
3. Increase productivity and increase patient flow.
4. Ring fence the remaining growth and COVID reserves. AW highlighted that work has been undertaken in this area and agreement reached as to what will and will not be spent. However, if no further growth monies are spent, the Minister for Health and Social Services must be informed as political commitments made last year cannot be delivered.

One conclusion reached is that if through having substantive staff, HCS becomes a safer and more productive organization, this increased productivity could be used to generate income through private practice. However, simply swapping locum / agency staff for substantive staff will not save much money. Resources need to focus on the review of the highest value contracts with the support of procurement experts (based in Commercial Services).

AW noted that budget holders and managers in HCS still cannot see their budget following the change to the new finance system. HMT advised this is an issue that must be brought to the attention of the external Auditors. ACTION: HMT and CB will discuss the lack of budgetary information available to budget holders with KPMG.	CB / HMT

14	**Workforce Report**	**Action**
Paper taken as read.		

15	**Cultural Change Programme**	**Action**
Paper taken as read.		

16	**Update on the 61 recommendations from the Review of Governance Arrangements within Secondary Care**	**Action**
Paper taken as read.		

17	**Assurance Committee Terms of Reference**	**Action**
Paper taken as read.		

18	**New Healthcare Facilities (NHF) Update and Feedback following Feasibility Study**	**Action**
Deferred due to annual leave.		

19	**Freedom to Speak Up Guardian – Themes**	**Action**
AMN was welcomed to the meeting. Noting the recent introduction of this role in HCS, HMT advised that the framework and approach continues to be developed. However, it is important to discuss the themes arising and the process by which concerns are managed. AMN summarised the key points detailed in the paper, noting that common themes arising are, • concerns regarding working relationships • lack of process • compliance with processes already in place. Both patient safety and worker safety cut across the themes arising. HMT invited comment / questions – non received. The FTSU Process Pathway was discussed although it was acknowledged that this is evolving as the service continues to embed. It was agreed that cases will continue to be allocated to an Executive Director who will coordinate an appropriate response, but this approach will be reviewed in the future.		

CP asked how we can determine if a positive difference is being made to those who raise concerns. AMN responded that feedback would be sought from the individual who raised concerned. However, it was acknowledged that HCS cannot necessarily respond in the way that individuals who raise concerns want, however, it is important that HCS does act in response to concerns raised. In addition, the recording of this information remains in development, particularly regarding recording the information in such a way that patterns can be identified and brought to the attention of the Executive Directors.	

20	**Anti-Racism Statement**	**Action**
WG in attendance and the Board received a verbal summary of the paper. CB thanked WG and explained that following discussions with staff from minority groups in HCS, their experience (recognising the absence of detail of Workforce Race Equality (as in the UK)) of working within HCS is different. This includes feeling unsupported by managers when dealing with racist behaviour from service-users, families of service-users and colleagues. However, it is recognised that managers themselves are unsure how to manage racism in the workplace and may themselves feel unsupported. CB will be meeting with the States of Jersey Police to discuss their response to complaints of racism raised within HCS and potential prosecutions. The importance of positive action, supported at Board level, was discussed. It was noted that there is no Public Sector Equality Duty and there is a lack of data relating to this area in Jersey. In response to SMKs question, ethnicity is not regularly recorded for staff and service-users. In reference to the 30 reported incidents of racial abuse across HCS towards staff from patients / relatives, HMT asked what the outcomes were. WG explained that the outcomes varied from no action taken to notifying the Police. Noting the feedback from staff that incidents go unreported due to the perception that no action is taken, HMT asked for the 30 cases to be reviewed to determine whether the action taken (or not) was appropriate. ACTION: WG and CP asked to review the 30 reported incidents of racial abuse to determine whether the action taken was appropriate or inappropriate and report back to the Board in Oct 2023, particularly any incidents of racial abuse from one staff member to another. The recollection of WG is that there are no reported incidents of abuse from one staff member to another, rather they all relate to racial abuse from service-users (and family members) to staff. AW advised the Board that two assaults on staff in Orchard House were successfully prosecuted. However, it required the Director of Mental Health Services and Adult Social Care to discuss this with the Chief Police Officer. This was the level of escalation required to elicit action and advised that inappropriate action may not be because of lack of effort. It was agreed that the routine use of equality impact assessments would help HCS to identify what could be done differently. Whilst noting the interrelationship, the importance of distinguishing health inequalities from workforce race equality was discussed and agreed. This statement is concerned with workforce race equality, and this is the area of focus. This work received the full support of the Board. It was agreed that the focus group could be established.	WG, CP

ACTION: SG and CP to report back to the Board about the next steps to be taken regarding incidents of racial abuse from service-users (and families) to staff and staff member to staff member.	SG, CP

	PART A MEETING CLOSE	**Action**
Date of next meeting: Wednesday 23rd August 2023.		

Health and Community Services Advisory (Shadow) Board

Health and Community Services

Date: 23 August 2023	Time: 2:00 – 4:00pm	Venue: PCH 3rd Floor West Wing Board Room

Attendees:		
Professor Hugo Mascie-Taylor - **CHAIR**	Fixed-term Chair of the Board	**HMT**
Christopher Bown	Chief Officer HCS (Items 3 onwards)	**CB**
Andy Weir	Director of Mental Health Services and Adult Social Care	**AW**
Jessie Marshall	Chief Nurse	**JM**
Professor Simon MacKenzie	Medical Lead – HCS Change Team	**SMK**
Cathy Stone	Nursing and Midwifery Lead – HCS Change Team	**CS**
Dr David Hopkins	(Interim) Chief of Service Women, Children and Family Care	**DH**
Mr Simon West	Deputy Medical Director deputising for Patrick Armstrong, Medical Director	**SW**
Jo Poynter	Associate Director of Improvement and Innovation deputising for Anuschka Muller, Director of Improvement and Innovation	**JP**
Dawn Johnstone	(Interim) Head of Midwifery	**DJ**
James Mason	Acting Head of Operational Resilience deputising for Claire Thompson, Director of Clinical Services (TEAMS)	**JMas**
Maria Finn	Emergency Department Consultant deputising for Adrian Noon, Chief of Service Medicine (TEAMS)	**MF**
Emma O'Connor	Board Secretary	**EOC**

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

HMT welcomed all to this extraordinary Board that he had called as a result of conversations with the Change Team and reports which had been written regarding quality and safety.

Apologies received from:

Chris Bown	Chief Officer HCS – Late Arrival	CB
Patrick Armstrong	Medical Director	PA
Anuschka Muller	Director of Improvement and Innovation	AM
Claire Thompson	Director of Clinical Services	CT
Adrian Noon	Chief of Service Medicine deputising for Patrick Armstrong, Medical Director	PA
Cheryl Power	Director of Culture, Engagement and Wellbeing	CP
Steve Graham	Associate Director of People HCS	SG
Sophia Bird	Head of Communications HCS	SB

In addition, a progress up-date was provided regarding recruitment to the Board with a potential date for the first meeting in public.

HMT made these general points about Board behaviours which were endorsed by those present.

- "Actions" are not optional: they must be completed unless agreed with the Chair in advance.

• All actions must be assigned to an Executive Director who has overall accountability for delivery. The process for completing the action is a matter for the Executive Director and how they chose to deploy those who account to them. • If an Executive Director feels that insufficient time has been allocated to complete an action, this must be raised during the meeting when the action is agreed. • It should be foreseen that when an action is taken or a policy set, Non-Executive Directors (NED) will ask how ongoing compliance will be assured and how the Board will be assured of compliance, i.e., this is what we intend to do, this is how it will be measured, and this is how the Board will be assured there is compliance. Describing this as part of the response to the action required is very helpful. • In the absence of Executive Directors, an appropriate deputy must be sent (with Chair's approval). However, whilst recognising that some absences may be unavoidable, the expectation is that Executive Directors will attend all meetings of the Board. • On the report template, it was agreed that '*sponsor'* should be replaced with *'accountable executive'* so that it is clear which Executive Director is accountable. • The preferred position is that Executive Directors present their papers. However, there may be circumstances where it is beneficial to have the report author in attendance. This must not distract from who has overall accountability: the Executive Director. (CS commented that whilst having a subject matter expert may be helpful, Executive Directors, should have knowledge of their portfolio. It is not acceptable to see the authoring of papers continually delegated to others i.e., junior members. It was also agreed that papers being written by the members of the project management team (PMO) team is unacceptable as the PMO team are there to support from a project management perspective, not the delivery). • Executive Directors are responsible for ensuring that papers are submitted on time. Consequently, the Executive Directors must communicate with those who account to them. It is not the responsibility of any other individuals to follow up late papers.	

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

3	**Maternity Services**	**Action**
An overview of the key issues described in the tabled paper was provided to the Board by the Interim Chief of Service for Women, Children and Family Care, endorsed by the Executive Directors and the Change Team. Points arising in discussion included, Referencing paragraph 6 in the report – "*However, following the arrival of the change team in February 2023, it became evidence that Professor Mascie-Taylor's recommendations had not been implemented and any changes previously implemented following the incident had either not been sustained or had become out of date"*. HMT noted two points, - this may indicate that the service was potentially unsafe,		

- that the service continues to be potentially unsafe despite assurance having been provided that it was not unsafe. DH responded that this is why it is critical to build the mechanisms which have not previously existed to provide assurance. In addition, there is also a cultural issue regarding perception of quality which can be evidenced through audit results which have previously been accepted without evidence of action taken in response. One element of the Maternity Improvement Programme (MIP) is how to ensure appropriate reporting within the performance reviews and escalation to the Executive Directors. In addition, looking to establish which metrics to include that will provide clear assurance on quality. HMT asked what HCS should be measuring. DH responded that this must include core data regarding the safety of labour and monitoring and providing consistent assurance that the processes regarding the management of labour are being followed. ACTION: DH / DJ to present to the Board an appropriate suite of performance metrics and how the organisation is performing against them. ACTION: In reference to the five workstreams, a report for the meeting of the Board in October 2023 has been requested which is to include, what exactly are these areas, which Executive Director is responsible for them, what progress has been made so far and when is further progress expected to be made. The recommendations in the paper were endorsed. A further discussion took place regarding guidelines. It was proposed and supported that Jersey should benchmark against England: Jersey has clinical partnerships with centres in England, the professional regulators are English and Jersey has also adopted NICE / Royal College guidelines. It was noted that whilst this can be discussed at the Board, benchmarking remains a policy decision for the Minister and HCS to enact. ACTION: HMT to discuss benchmarking with the Minister for Health and Social Services. The importance of process to agree where a National Guideline is not followed in Jersey was discussed. For example, where National guidelines were not felt to be appropriate. It was agreed that if HCS is to adopt its own unique policy then this must be agreed by the Board in a meeting in public following a recommendation from the Medical Director or Chief Nurse. ACTION: For the meeting of the Board in October 2023, a position statement from the Medical Director regarding recommendation 7 in the Review of Governance Arrangements by Professor Hugo Mascie-Taylor. The paper is to include a description of the way in which policies are adopted and enforced in HCS. It should be noted that rather than simply evidencing the existence of a policy, evidence of compliance with the policy will be required. If unable to evidence compliance, then the Board will wish to know how this will be achieved and when. This should be included in the Medical Director's position statement.	CT CT HMT PA

4	**Acute Medicine Service**	**Action**
The paper was tabled, and its findings and recommendations endorsed following three corrections having been made.		

In discussion, the Board's attention was drawn to the recommendations (page 6). The findings of the Royal College of Physicians (RCP) were highlighted – "*Whilst the initial care of the patient was considered 'good care' by the review team, the care received after 24-72 hours (post-admission) was considered mostly 'poor care'".* It was also pointed out that an RCP report in 2014 identified many of the same problems and did not result in any significant change. HMT noted the link to job planning and transparency regarding what is required. Consultant staff are highly paid individuals who account to the organisation, HCS must know how they are deployed and hold them to account for doing so. It is a contractual requirement, and it is in both the interests of Doctors and HCS to have up-to-date job plans. It may well be revealed that there are insufficient professional activities (PAs) available to provide the cover required by the organisation. However, clarity and probity are essential features of good governance. ACTION: An accurate update on job planning (for named individuals) including all aspects of job planning (clinical sessions, private practice, supporting professional activity (SPAs etc.) and indicate if not completed, when it will be completed. Job plans should then be made available to all interested parties, including clinical areas and the Board.	PA

5	**Any Other Business**	**Action**
Areas of concern which have been brought to the attention of the Chair and require clarification regarding quality and safety include, • <u>How are Consultant appointments made?</u> A discussion took place as to how Consultant appointments are made. ACTION: HR to produce a discussion document for the Board meeting Oct 2023. At a minimum this should include a discussion about • Should proposed Consultant appointments be approved by the Board prior to the States Employment Board (SEB)? • Which Executive Director is responsible for bringing these to the Board? • Who signs off the financial arrangements? • Who signs off the safety arrangements? • As an example, using a recent appointment, who has signed this off as above? • How are Consultant appointments prioritised (considering pressures across HCS)? • <u>General Surgical Acute Rota – Medical Director</u> ACTION: Medical Director to produce a report for the meeting in Oct 2023 on the general surgical acute rota. • <u>Pending Inquests</u> ACTION: Regarding the upcoming inquests (Mental Health Services and Maternity), HMT advised by CB will decide whether an extraordinary Board is required to discuss.	CB (SG) PA HMT / CB

• Storage of Guidelines A discussion took place prompted by DH about the collation and availability of policies, procedures etc. ACTION: The Director of Mental Health Services and Adult Social Care and the Nursing Lead for the Change Team to prepare a report for the meeting on October 2023 on how procedural documents should be managed and presented to the SLT. • Project Management Support (PMO) Prompted by HMT, a discussion followed regarding the benefits of project management support to improvement plans across HCS. ACTION: This is an ongoing consideration for CB and HMT as to how to progress (Oct 2023)	AW HMT /CB

	MEETING CLOSE	**Action**
Date of next meeting: Wednesday 4th October 2023		

Health and Community Services Advisory Board Meeting

4 October 2023

Chief Officer Report

1. Introduction

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

2. Key issues

a. Government Plan 2024 -2027 and Financial Recovery Plan

In the aftermath of the Covid-19 pandemic, the Health and Community Services department is facing a range of challenges including financial pressures of up £35 million. This is driven by both factors in the direct control of the department, and structural factors outside of their direct control.

A team to deliver a Financial Recovery Programme (FRP) has been put in place in 2023, and a comprehensive plan is expected to be produced by the autumn of 2023 which will be presented to the Board. Ministers have recognised in the Government Plan that it will also be essential to ensure that central functions are aligned to support the department in resolving some of the operational challenges.

As part of delivering the FRP, this funding will be used to maintain existing healthcare services that are facing further inflationary activity and efficiency related cost pressures. Examples of these services are mental health placements, social care packages, high-cost drugs, off-Island care, expansion beds and cancer services.

The recovery plan will identify opportunities for improved efficiency and effectiveness of services to help reduce costs and ensure that the service can be delivered within the revised cash limits, reducing spend by £25 million a year by 2025. The Council of Ministers have recognised that the delivery of these savings will take time, and it is anticipated that not all structural elements can be resolved without impacting healthcare services and patients. A proposed further £21m has therefore been allocated to the department in 2024, reducing to £15m in 2025 onwards to maintain healthcare services.

A second workshop on the FRP was held in September, attended by over 70 HCS colleagues, and savings programmes were presented.

b. HSC Business Plan

A HCS 2024 Business Plan in line with the Ministerial Plan 2024 will be developed for agreement by the Board in December/January 2024. The plan will provide a high-level view of the department's key priorities and workstreams for 2024 and will include summary actions and targets, which will be reported on throughout the year at to be confirmed intervals. It is anticipated that this document will be publicly available to provide transparency of HCS' overarching performance.

c. Clinical Governance

The decisions made by the HCS Senior Leadership Team (SLT) and supported by the Change Team to strengthen clinical governance are now being monitored to ensure compliance, for example, Serious Incidents (SIs), complaints management, clinical guidelines compliance. Strengthened Care Group clinical governance meetings have been established to support this with attendance of the Change Team members to provide external challenge.

d. Rheumatology

The review of the rheumatology service by the Royal College of Physicians continues and an update will be provided at the Board.

e. Electronic Patient Record (EPR) Implementation

Work continues to manage the implementation with a focus on ensuring good governance and improving processes for clinicians as there continues to be challenges with the system's implementation, including an impact on the waiting list data in both acute and mental health services. The EPR team continue to respond ensuring improvements in the initial stages of this system's implementation.

A close working relationship has been developed between HCS and Wye Valley who successfully implemented IMS Maxims a few years ago to enable learning and exchange of experiences and expertise between the technical and clinical teams.

f. Maternity Improvement Plan

This work is a priority for the Chief of Service Women and Children's Care Group, the Executive Directors and Change Team. An update will be provided during the Board meeting.

g. Acute Medicine Improvement Plan

Following a report from the Royal College of Physicians (RCP), the Chief of Service for Medicine, the Medical Director from the Change Team and the Executive Directors have considered the changes needed to remodel the service and bed stock to improve safety, quality, and efficiency. A priority must be to improve the availability of consultants to undertake regular ward rounds and increase the medical bed stock, which in turn will support an increase in elective activity. The SLT have now agreed the bed configuration plan which includes an increase in capacity.

h. New Healthcare Facilities (NHF) programme

The multi-site healthcare facilities planning work continues including the work associated with the demolition of the Overdale site. The relocation of services from Overdale to the new Enid Quenault Health and Wellbeing Centre has now been completed with many positive comments from staff and patients. The need for new healthcare facilities remains central to the future of healthcare in Jersey.

i. Cultural Change Programme.

Work continues to develop this programme with particular focus on providing an environment for staff to speak up and address incidents of bullying and discrimination. The Government 'Be Heard' Survey results have been provided and will be included in the cultural change programme but will focus on specific areas that require the greatest attention and support. The Chief Officer continues to hold monthly staff listening ('Teams Talks') events where over 65 staff attend. We are increasingly seeing staff's willingness to speak up both through the Freedom to Speak Up Guardian and directly which is a positive development.

j. Cancer Services

As we move forward with the launch of a cancer strategy, several projects have been implemented in oncology. These include the Cancer Multidisciplinary Team (MTD) co-ordinators and a Cancer Survivorship Clinic and a holistic needs assessment collaboration project with MacMillan.

k. Waiting Lists

Procurement is underway to secure additional capacity to reduce waiting lists/times supported by a £5 million investment from Government and a report will be provided to the Board on progress.

l. Workforce

A priority focus has been and will continue to be on the recruitment of substantive employees with agency and locum usage remaining too high. This is a key aspect of the FRP with significant savings to be achieved as well as improved service quality. This work will be covered in the Board's workforce report.

3. Performance Summary

a. Quality

Whilst we continue to receive both positive and negative feedback from patient, relatives and carers, we have increased evidence of engagement both face to face and written correspondence with complainants and families.

Avoidable harm, quality and safety indicators. August has seen a decrease in the number of pressure ulcers acquired in HCS which is now below the UK national average.

Monthly interactive training sessions on pressure ulcer prevention and management continue.

Infection Control. There have been no outbreaks during August and zero incidents of Clostridium Difficille (C. Diff) or MRSA against a background of increased activity.

Falls. There has been an increase in prevalence during August. A new falls policy is in development and implementation will be supported by training and education.

Nutrition and Hydration. HCS are in process of developing a Nutrition and Hydration strategy in partnership with service users. Ahead of the strategy this month we have introduced protected mealtimes.

b. Performance: Acute Hospital Services

Waiting Lists: The new Electronic Patient Record (EPR) implemented in the last weekend of May 23 has contributed to growth in the waiting list PTL (Patient Tracking List) for the following reasons:

- Planned reduction in activity in the weeks immediately following implementation.
- Embedding of new processes, specifically the interaction between the Emergency Department (ED) and follow-up activity in scheduled care, the requirement for clinicians to input into the EPR at point of care and the admission process (TCI) in theatres.
- Significant changes to the structure of reporting and the organisation of data, particularly in relation to the PTL, for example HCS no longer has the ability to suspend patients awaiting elective operations for social reasons, consequently these patients are now reported in the overall waiting list volume until a technical solution is realised.

Despite this the community dental commissioning scheme continues to deliver, and the total waiting list volume has decreased by 58% since the pilot phase in October 2022. The additional waiting list funding provided by Government has formalised into a programme of work that has commenced across several services. The endoscopy insourcing project is due to start on 7 October, which will complete an additional 1,664 JAG (Joint Advisory Group – Gastro-Intestinal (GI) Endoscopy) points of activity (approx. 800 patients) for 16 weekends. Additional lists have been completed in Ophthalmology, Echocardiography and Upper GI Surgery during August and several initiatives are in the planning and procurement phase.

Specialty outliers including Ophthalmology, Dermatology and Clinical Genetics have recovery plans in place that include additional sessions, pathway development and insourcing / outsourcing of clinical activity.

Overall, the Inpatient PTL remains static despite the decrease in clinical activity post EPR go live. The EPR is a Commissioning Data Set compliant system which offers granularity to datasets, which were previously not available in the old system. This is supporting the scheduling and booking processes within TCI by predicting operation length per surgeon so that utilisation of lists is based upon actual performance and not opinion. Both theatre recruitment and inpatient bed capacity remain as limiting factors to increasing the rate of improvement delivery in inpatient elective care and remains a focus of both the waiting list and financial recovery programmes.

A Magnetic Resonance Imaging (MRI) waiting time reduction plan has also been established with significant improvements expected by the end of 2023.

Emergency care. Overall, growth is noted in emergency attendances and admissions, however an improvement has been noted in the ED conversion rate with the quality indicators now being met. A continued increase in the number of patients delayed in hospital has been noted, which has compounded ED patients with a stay greater than 10 hours which has increased from 36 in July to 76 in August. The number of patients who are medically fit for discharge remaining in hospital (currently c.40) is a major issue for both patients and HCS, and work continues with partners on how this can be best reduced.

To support redirection of emergency activity and following recommendations from the Royal College of Physicians and other visiting experts, an expansion of Same Day Emergency Care (SDEC) is being explored. Winter plans are in development to support operational flow and delivery, and this includes implementation of the Red2Green initiative, which will provide a greater understanding of internal and external delays within care pathways, implementation of a surgical hot clinic to facilitate re-direction of emergency activity and revitalisation of the 'golden patient' initiative to increase the number of discharges which take place before midday.

c. Mental Health and Social Care.

Since the implementation of the new Electronic Patient Record, there has been some difficulties with reporting all performance data for mental health services; This is currently being resolved, but some July data is not yet available.

In relation to the implementation of the new community mental health model, the service continues to achieve its target of seeing all appropriate crisis referrals within four hours (97% in June) and routine referrals within 10 working days (83% in June). Where this is not achieved, this is frequently due to service user choice or inability to make contact with the service user within the time frame. This is being monitored on a case-by-case basis each month. Work is now underway to begin to evaluate the implementation of the new Care and Recovery Framework, including the quality and range of interventions provided by the Community Mental Health Teams.

The roll-out of our Quality Improvement (QI) initiative across the three inpatient mental health wards is underway, with current work focussing on the philosophy of care, quality of documentation, admission and discharge processes, staff wellbeing and medication management. It is unfortunate that the relocation of Orchard House to the refurbished Clinique Pinel building has been further delayed; we hope that this will now be completed in December.

The most significant challenge for mental health services continues to be waiting times for psychological therapies and diagnostic services (Attention Deficit Hyperactive Disorder (ADHD), autism and dementia assessment). Each of these areas experiences significant staffing pressures (often where specialist expertise is required to diagnose, and despite multiple attempts to obtain additional staffing capacity) alongside increased demand. This has resulted in an increased waiting time across these services in recent months. Detailed work is being undertaken in each of these areas to seek to improve the position, which includes exploration of other short-term provision, and a detailed report is being prepared in relation to this for the SLT and the Minister by the Director of Mental Health and Adult Social Care.

Adult social care continues to move slowly towards meeting the target of 80% of clients with a learning disability having a physical health check (76% in July) and have recovered their KPI in relation to assessments completed and authorised within three days (85%). The service continues to be challenged by the target to review all support plans within six weeks, in part due to delays in services commencing and other operational pressures on the team. This will continue to be reviewed and prioritised by the service. Work is also ongoing between the Social Care leadership team and the Intermediate Care team to further develop our hospital discharge service, to support flow and increase available capacity within the hospital.

d. Finance

The Year-to-date (YTD) overspend in August M8 is £18.9m vs budget rising by £2.8m in-month. The FY23 year-end forecast remains at a deficit of £29.0m.

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
HCS Categorisation	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Staff Costs	15,104	16,832	129,671	132,880	(3,209)	197,312	202,309	(4,997)	(2.5%)	(2.5%)
Non Pay	8,243	8,310	63,315	76,279	(12,964)	90,795	113,167	(22,372)	(20.5%)	(24.6%)
Income	(2,146)	(934)	(16,751)	(14,046)	(2,705)	(26,207)	(24,576)	(1,631)	16.1%	6.2%
Grand Total	**21,201**	**24,207**	**176,236**	**195,113**	**(18,877)**	**261,900**	**290,899**	**(29,000)**	**(10.7%)**	**(11.1%)**

Key drivers of the overspend are:

- **Pay** overspend of £3.2m YTD agency usage in August of 205 full time equivalents (FTEs) across Medical Services, Surgical Services, and Women and Children, which is substantially mitigated by vacancy underspends across other areas due to vacancies of 516 FTEs leaving a net overspend position. This forecast to rise to £5m by year-end FY23 driven by a £23.2m overspend on agency locums partially offset by an £18.2m underspend on substantive staffing due to vacancies.

  The increase in forecast agency costs is mainly due to further extension of bookings, rate increases driven by stricter application of Jersey tax rules regarding agency workers, and additional agency staff.

- **Non-Pay** is £13m adverse to budget which includes £8.5m part-year effect of the opening budget pressure with the remaining £4.5m due to Mental Health placements and drugs, Tertiary Care, and Social Care domiciliary care packages. The year-end FY23 forecast is £22.4m adverse consisting of a £13.9m opening budget pressure and £8.5m spread across Care Groups, Non-Clinical Support, and Estates and Facilities.

- **Income** has under-achieved by £2.7m from Surgical Services underperformance of £2.2m on private patient income due to lack of surgical beds capacity from medical outliers, and a £0.4m underperformance in Social Care. The year-end FY23 position shows a net underachievement of £1.6m from private patient income, made-up of £3.4m income loss offset by an over-recovery of Long-Term Care Benefit income.

The Financial Recovery Plan (FRP) has just been completed at the time of writing and commits HCS to an in-year savings delivery of £3m by the year end requiring a run-rate reduction of £1m per month.

The reserves position is £2.93m made-up of growth, Covid and capital reserves. This has now been frozen to ring-fence in partial mitigation against the in-year deficit position.

Risk and issues

The risks to the year-end forecast as follows:

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

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

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

e. Workforce

An increase in funded establishment due to Government Plan and business case funded roles coming online from January 2023 has increased funded establishment by 176 WTE since the beginning of 2023, this has had a corresponding impact on the overall vacancy number which has increased as has the vacancy rate and the agency numbers. HCS is currently reporting 527 WTE vacancies at a vacancy rate of 18%.

Recruitment to substantive roles continues to be the main focus across HCS, with several approaches being adopted to increase the attraction element of HCS as an employer. A microsite is being designed for all nurses' roles and specialist recruiters have been engaged to assist with identifying candidates for hard to fill roles.

The total turnover rate has increased this month to 7.3%; this increase is due mainly to the junior doctor rotation which took place in August when 27 WTE ended their fixed-term placement with HCS. It is down from 8% this time last year. The voluntary turnover rate (i.e., resignations) has also remained constant at 4%; this is equivalent to 106 staff resigning over the previous 12 months. In that period HCS has over 299 new starters, which is a mix of people new to HCS and people within HCS taking up alternative roles.

The sickness absence rate has increased slightly to just over 4%, with the main reason for absence continuing to be coughs, cold and flu over the last month.

The August data for the objective setting shows some movement in the approval of objectives and the mid-year reviews with an increase from 0.3% to 6.8% of the workforce having a mid-year review. However, this is still low and will remain an area of focus for Executive team.

4. HIGHLIGHTS OF STAFF ACHIEVEMENTS

Highlights of Staff Achievements and Engagements

An outstanding number of Our Stars nominations (445) were received for HCS staff across a range of clinical and non-clinical groups. The Government of Jersey Sustainability Champion Our Stars award was won by our Infection Sciences team and the award for Government Employee of Year went to Evelina Czachor. Eveline is a Social Worker in the Adult Social Care team, has supported Islanders in the aftermath of the tragic incidents in 2022/2023 and has also previously worked in the Improvement Team on designing new services.

We have continued to build efficiency and a culture of listening and action through a range of staff engagement events. The inaugural launch of Schwartz Rounds in HCS, a forum for clinical and non-clinical staff to come together and discuss the emotional and social aspects of their role, commenced in February 2023. Seven monthly Schwartz Rounds have now been delivered and attended by 248 staff.

During 2023, six breakfasts have been hosted by the Chief Officer and attended by 44 staff who have been recognised by their colleagues for a significant achievement as part of their role.

To improve connectedness and strengthen relationships a number of initiatives outside of work have been set up. The Dragon Boat Festival was attended by more than 100 clinical and non-clinical staff representing HCS, resulting in HCS being finalists and coming 5th position out of 46 dragon boats. A mixed netball team representing HCS staff entered a 10-week tournament against other organisations across Jersey.

Report to:	Health and Community Services Advisory Board		
Date of meeting:	4 October 2023		
Title of paper:	Finance Report		
Report author (and title):	Obi Hasan, Finance Lead Change Team, Interim Head of Finance Business Partnering HCS	**Accountable Executive:**	Chris Bown, Chief Officer HCS

1. Purpose

What is the purpose of this report?	To provide an update on the Month 8 (M8) Financial position and year-end forecast	Information	
		Decision	
What is being asked of the HCS Advisory Board?	To discuss current financial position and year-end forecast noting the risks and mitigations.	Assurance	
		Update	x

2. Executive Summary

The Year-to-date (YTD) overspend in August M8 is £18.9m vs budget rising by £2.8m in-month. The FY23 year-end forecast remains at a deficit of £29.0m.

Key drivers of the overspend are:

- **Pay** overspend of £3.2m YTD agency usage in August of 205 FTEs across Medical Services, Surgical Services, and Women and Children, which is substantially mitigated by vacancy underspends across other areas due to vacancies of 516 FTEs leaving a net overspend position. These are forecast to rise to £5m by year-end FY23 driven by a £23.2m overspend on agency locums partially offset by an £18.2m underspend on substantive staffing due to vacancies.
- **Non-Pay** is £13m adverse to budget which includes £8.5m part-year effect of the opening budget pressure with the remaining £4.5m due to Mental Health placements and drugs, Tertiary Care, and Social Care domiciliary care packages. The year-end FY23 forecast is £22.4m adverse consisting of a £13.9m opening budget pressure and £8.5m spread across Care Groups, Non-Clinical Support, and Estates and Facilities.
- **Income** has under-achieved by £2.7m from Surgical Services underperformance of £2.2m on private patient income due to lack of surgical beds capacity from medical outliers, and a £0.4m underperformance in Social Care. The year-end FY23 position shows a net underachievement of £1.6m from private patient income, made-up of £3.4m income loss offset by an over-recovery of Long-Term Care Benefit income.

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The reserves position is £2.93m made-up of growth, Covid and capital reserves. This has now been frozen to ring-fence in partial mitigation against the in-year deficit position.

3. Risk and issues

The risks to the year-end forecast as follows:

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

4. Main Report

The Year-to-date actual vs budget overspend has increased by £2.8m in M8 to £18.9m. The FY23 year-end forecast is a deficit of £29.0m which is an increase of £0.4m vs last month.

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The key drivers are:

Year-to-date position:

- **Staff Costs £3.2m overspend-** Includes significant overspends in Medical Services £6.2m, Surgical Services £2m, and Women and Children and Family Care £1.1m, where agency usage (totalling 205 FTE) and other temporary workforce has been used to cover vacant roles and staff absences. This is substantially mitigated by vacancy underspends across other areas in relation to cover of vacant posts (516 FTE).
- **Non-Pay £13.0m overspend-** This includes £8.5m part-year effect of the opening pressure. The remaining £4.5 m overspend includes Mental Health on off-Island

placements and drugs £2.4m, Tertiary Care £1.1m, Social Care on domiciliary care packages £0.8m, and Surgical Services £0.8m.

- **Income under-achievement £2.7m** - Surgical Services has underperformed by £2.2m against private patient income targets, and there is a £0.4m underperformance in Social Care.
-

FY23 year-end forecast:

- **Staff Costs are forecast to overspend by £5.0m** including an £18.2m underspend on substantive staffing due to vacancies (516 FTE), and a £23.2m overspend on agency locums (205 FTE). The month-on-month movement is a forecast increase of £0.8m, driven by an agency expenditure forecast increase of £1.9m, offset by a substantive staffing forecast reduction.
- **Substantive Pay underspend £18.2m** is made up of underspends from vacancies in Mental Health £5.9m, Surgical Services £3.7m, Medical Director £2.1m, Women, Children and Family Care £2.1m, Primary Care and Prevention £1.8m, Chief Nurse £1.2m, Non-Clinical Support Services £0.8m, Estates and Hard Facilities Management (FM) £0.6m, Social Care £0.3m, and Improvement and Innovation £0.2m. These are offset by a forecast overspend in Medical Services of £2.5m.
- **Agency overspend £23.2m** is in Medical Services £6.6m, Surgical Services £6.5m, Mental Health £4.1m, Women and Children's Services £3.3m, Primary Care £1.2m, Medical Director £0.4m, Jersey Care Model and Chief Nurse both £0.3m.
- **£22.4m overspend on non-Pay-** £13.9m financial pressure, remainder across Care Groups, Mental Health £2.8m, Social Care £1.8m, Surgical Services £1.7m, Tertiary Care £1.3m, Medical Services £0.9m, Jersey Care Model £0.5m, Non-Clinical Support and Estates both £0.4m.
- **£1.6m underachievement of Income-** due to a Surgical Services private patient income under-recovery of £3.4m, offset by an over-recovery of Long-Term Care Benefit income.

- **Movement in Agency vs Substantive Costs**

  The below table shows that vacancies have increased by 23 and agency by 11 FTE. The increase in forecast agency costs is mainly due to further extension of bookings, rate increases driven by stricter application of Jersey tax rules regarding agency workers, and additional agency staff.

  The increase of £1.9m is mainly seen in Women and Children £0.9m, Medical Services and Surgical Services £0.2m, and £0.5m across Jersey Care Model and Intermediate Care (Intermediate Care element previously in Medical Services, JCM not previously forecast as agency expenditure.

	June	July	August		June	July	August		June	July	August		June	July	August	
Care Group	Vacancy	Vacancy	Vacancy	Difference	Vacancy covered by Agency	Vacancy covered by Agency	Vacancy covered by Agency	Difference	Vacancy NOT covered by Agency	Vacancy NOT covered by Agency	Vacancy NOT covered by Agency	Difference	Agency Forecast	Agency Forecast	Agency Forecast	Difference
	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	Amount (£)	Amount (£)	Amount (£)	Amount (£)
Chief Nurse	16	16	**16**	**0**	**1**	**1**	**2**	**-1**	**15**	15	14	1	186,079	199,457	251,257	-51,800
Director General's Office - HCS	0	1	**12**	**-11**	**0**	**1**	**0**	**1**	**0**	0	12	-12	1,093,346	1,070,819	1,097,085	-26,266
Estates & Hard Facilities Management	8.4	8	**9**	**-1**	**0**	**0**	**0**	**0**	**8**	8	9	-1	0		0	0
Improvement & Innovation	3	9	**8**	**1**	**0**	**0**	**0**	**0**	**3**	9	8	1	0		0	0
Intermediate Care	0	0	**5**	**-5**	**0**	**0**	**2**	**-2**	**0**	0	3	-3	0	0	179,588	-179,588
Jersey Care Model	0	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	0	0	0	0	295,256	-295,256
Medical Director	23	23	**27**	**-4**	**4**	**4**	**4**	**0**	**19**	19	23	-4	442,468	420,268	420,268	0
Medical Services	87	81	**76**	**5**	**44**	**57**	**59**	**-2**	**43**	24	17	7	6,243,875	6,858,417	7,034,424	-176,007
Mental Health	122	119	**125**	**-6**	**39**	**39**	**40**	**-1**	**83**	80	85	-5	3,683,567	4,126,912	4,158,331	-31,419
Non-Clinical Support Services	35	40	**37**	**3**	**1**	**0**	**1**	**-1**	**34**	40	36	4		0	0	0
Primary Care & Prevention	31	35	**36**	**-1**	**11**	**18**	**18**	**0**	**20**	17	18	-1	1,171,930	1,184,530	1,150,570	33,960
Social Care	33	29	**32**	**-3**	**3**	**3**	**3**	**0**	**30**	26	29	-3	116,742	116,742	209,716	-92,974
Surgical Services	89	86	**86**	**0**	**50**	**55**	**52**	**3**	**39**	31	34	-3	5,602,930	6,765,982	6,920,097	-154,115
Women Children & Family Care	40	46	**48**	**-2**	**12**	**16**	**24**	**-8**	**28**	30	24	6	2,014,429	2,443,919	3,375,328	-931,409
Grand Total	**487**	**493**	**516**	**-23**	**165**	**194**	**205**	**-11**	**322**	**299**	**311**	**-12**	**20,555,366**	**23,187,046**	**25,091,920**	**-1,904,874**

5. Recommendation

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

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

END OF REPORT

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Workforce Report – August 2023 data		
Report author (& title):	Steve Graham, Associate Director of People, HCS	**Accountable Executive:**	Chris Bown, Chief Officer HCS

1. Purpose

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

2. Executive Summary

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

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

3. Finance / workforce implications

The report highlights the key workforce indicators.

4. Risk and issues

See main report.

5. Applicability to ministerial plan

See main report.

6. Main Report

See separate report.

7. Recommendation

The Board is asked to note the report.

END OF REPORT

Health and Community Services

Advisory Board

Workforce Report

September 2023

(August 2023 data)

Table of Contents

Introduction

The purpose of this report is to provide the Board with a suite of HR metrics relating to Health and Community Services.

Executive Summary

The table below shows a high-level month by month tracking of key HR metrics within HCS.

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

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

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

Work between the finance team and the HR Resource link team to reconcile the differences between systems has now completed and the Resource link hierarchy is being rebuilt to

reflect the reconciled position. An end of project report will then be published which will be shared at the next Board meeting.

The vacancy numbers through 2023 have increased due mainly to an increase in funding due to Government Plan and business case funded roles coming online from January 2023. This has increased funded establishment by 176 WTE since the beginning of 2023 and has had a corresponding impact on the overall vacancy number which has increased as has the vacancy rate and the agency numbers.

It is worth noting that whilst we have increased funded roles by 176 whole time equivalents (WTE), the number of vacancies has only increased by 116 WTE.

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

The total turnover rate has increased this month to 7.3%, this increase is due mainly to the junior doctor rotation which took place in August and 27 WTE end their fixed term placement with us. It is down from 8% this time last year. The voluntary turnover rate (i.e., resignations) has also remained constant at 4%, this is equivalent to 106 staff resigning over the previous 12 months. In that period HCS has over 299 new starters.

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

The August data for the objective setting shows some movement in the approval of objectives and the mid-year reviews with an increase from 0.3% to 6.8% of the workforce having a mid-year review. However, this is still low and will remain an area of focus for Executive team.

Recruitment

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

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

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

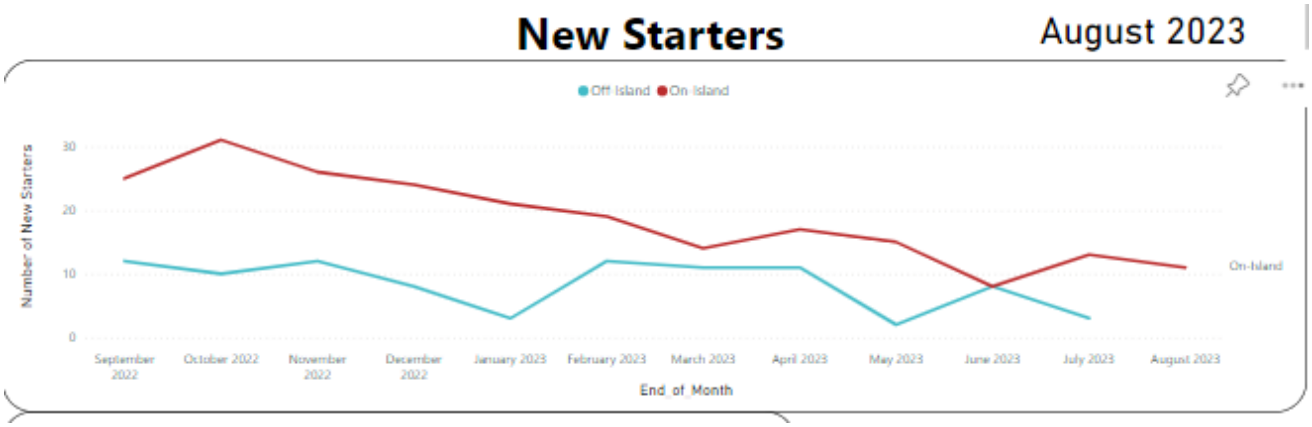
	Staff in Post (WTE)	
	Oct-22	**Aug-23**
Medical	188	204
Nursing	554	561
Healthcare Assistants	346	357
Civil Servants	759	841
Manual Workers	321	311
Total	**2168**	**2274**

The following table shows the vacancy rate for each staff group.

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

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

Over the last months HCS has recruited a total of 299 new starters. The number of on-Island v off-Island recruitment is shown below:



Recruitment Activity

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

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

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

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

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

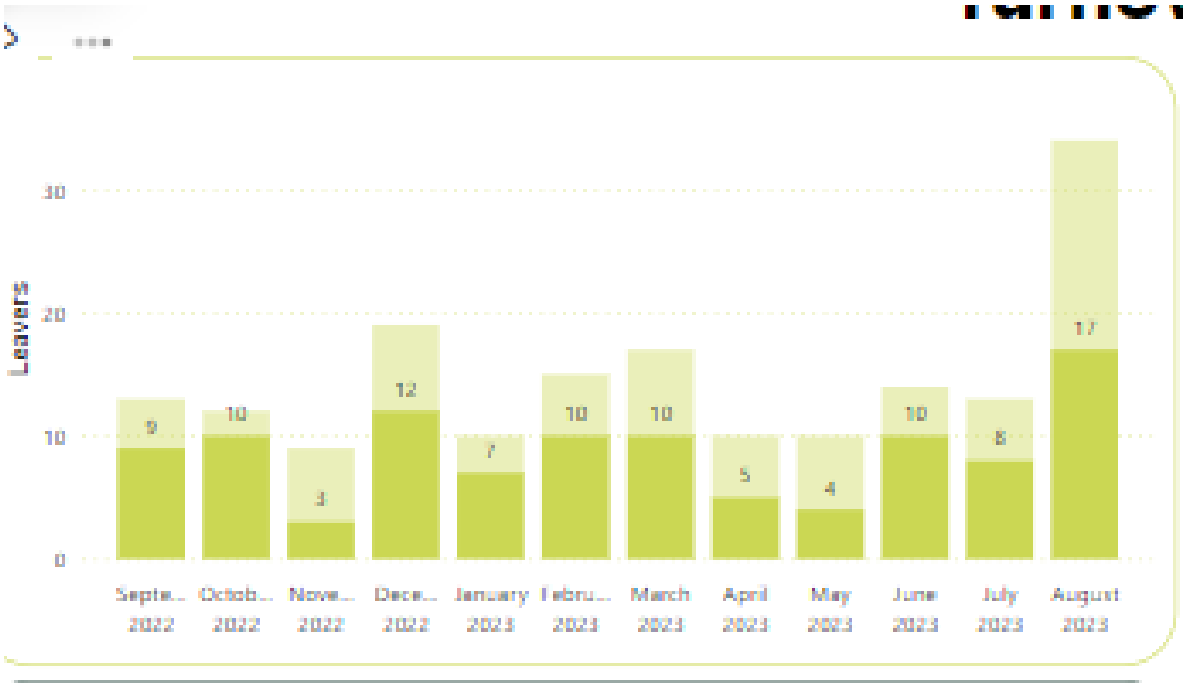
A redesign of the end-to-end process within HCS to ensure the “mass recruitment process” is successful and will introduce the concept of creating a bank of reserve second choice candidates.

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

Retention

The total turnover rate for the 12 months to the end of August is 7.3%, which equates to 177 people leaving HCS. The voluntary turnover figure (which relates to resignations) for the 12 months to end of August 2023 is 4.4%, down from 5.2% this time last year and 5% in the 12 months to the end of December 2022.

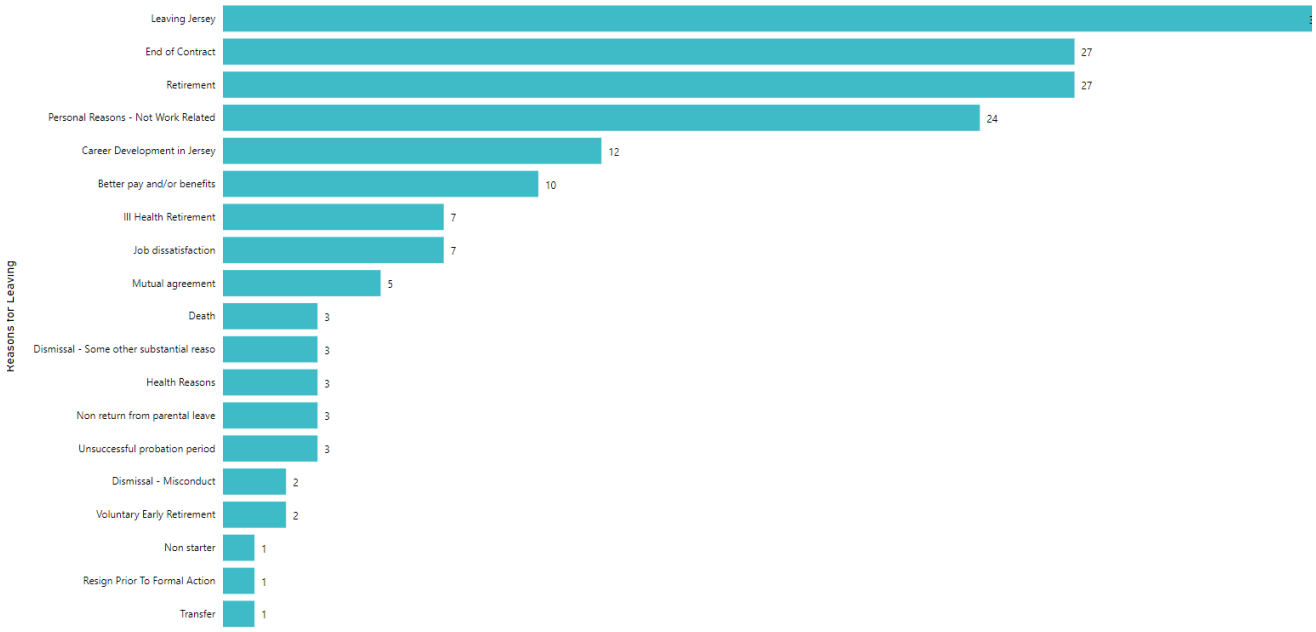
This equates to 106 leavers, spread across the year as shown below. The dark colour is the number of voluntary leavers per month, shown against the total number of leavers per month.



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

Exit Interviews

The graphic below shows the reasons provided for leaving for each colleague. This form is a centrally driven form and does not provide detailed explanation behind the reasons.



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

A previous analysis of the exit interview form is presented below and is from a sample size of 117 returned forms and is collated from the mix of free text and fixed responses in the leaver form.

From the analysis it is possible to identify four key themes that cover the common reasons for leaving. These are Career Opportunities and Development, Pay and Conditions, Change and Leadership and Learning and Development

The themes and the percentage of leavers giving that as a reason for leaving are shown in the table below.

The top reasons in each of the themes were:

<u>Career Opportunity and development</u>

- 26% left to further their careers.
- 16% deciding to leave Jersey.

- 9% were retirees.

Pay and Conditions

- 15% left for more flexibility and less pressure.
- 13% cited cost of living
- 10% left for better pay.

Change and Leadership

- 28% cited organisational change as a key reason to leave Health, with many commenting on changes post Covid placing more pressure on colleagues and less flexibility on day-to-day working life.
- 28% cited leadership skills as a reason for leaving.
- 8% cite the relationship with their manager.

Learning and Development issues

There was a common theme that development and educational opportunities have been disrupted since the Pandemic. There was a view that lack of equity in development opportunities across multiple disciplines within HCS and a lack of career route in some professions.

Common reasons applicants were attracted

The forms ask colleagues to identify what attracted them to Health and Community Services. In general, the data is lacking to produce much analysis of this area. This is not unusual given it is an exit interview, but it is useful to know why people were attracted to HCS in the first place.

35% of leavers mentioned pride in working for public sector as a reason for joining HCS.

Some of the key reasons for attraction that can be pulled from the data are:

Career Opportunity and Development

- 15% of leavers were attracted to HCS for a Career led opportunity.
- 14% identified they wanted a change of role or career.

Pay and Conditions

- 15% were attracted to Government by pay.
- 12% joined HCS for a better work like balance expecting this to be an advantage of working for Government.
- 4% expected to get more flexibility working in Government.

In addition, many of the comments revolve around the specialism of the nature of HCS and there being a limited number of health and care employers in Jersey.

A comparison between these two areas of the data immediately throws up a disconnect about the expectation of flexibility and work life balance available in HCS with the reality, with both being mentioned as reasons for attraction and a reason for leaving. There is something here about expectations of working in HCS and Government in general.

The theme of Learning and Development opportunities and career pathways also impacts on decisions to leave, with people leaving for opportunities elsewhere.

The data will be provided to us on a quarterly basis for analysis and reporting.

The analysis has shown that the data is powerful in identifying main reasons, but as a purely form-based survey it does not allow for any deeper insight into the reasons behind the decision to leave.

In December 2022 the HCS HR team introduced the offer face-to-face interviews for people leaving HCS. This proved to be successful both in the number of people who took up the offer (80% of leavers contacted requested a face-to-face interview) and the quality of information received (with the interview allowing for a more in-depth discussion on the issues faced by the individual and potentially identifying issues that would not have been noted on the form).

This process will be offered to all HCS leavers going forward, with the data collated together with that from the forms for further reports.

Induction

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

My Welcome

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

HCS Induction

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

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

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

Learning and Development

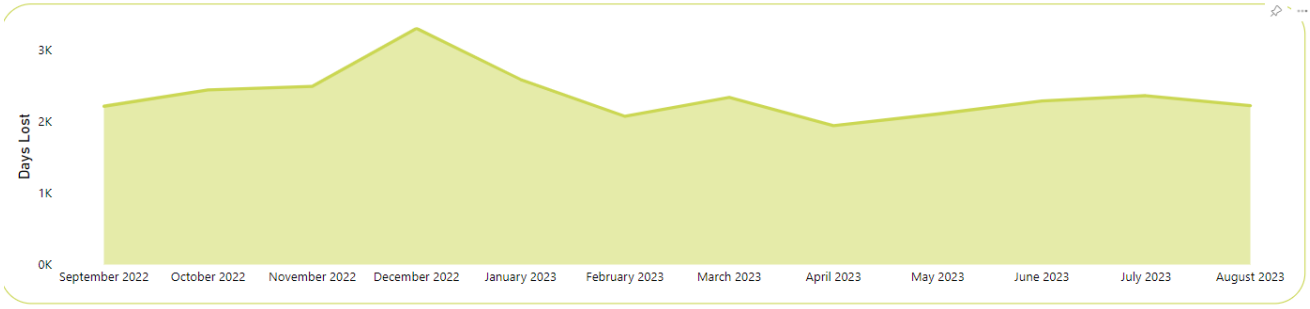
Statutory and Mandatory Training- Placeholder

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

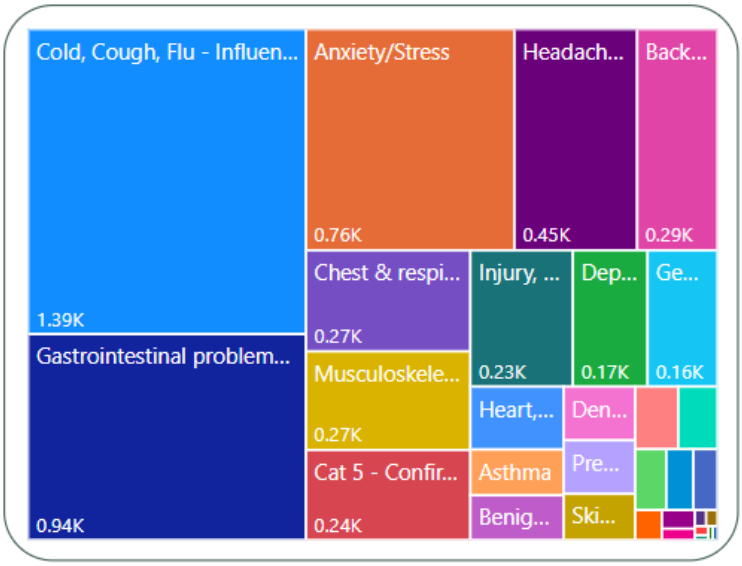
Health and Well Being

There has been a steady drop in the sickness absence rate from December 2022, which has halted over the last quarter.

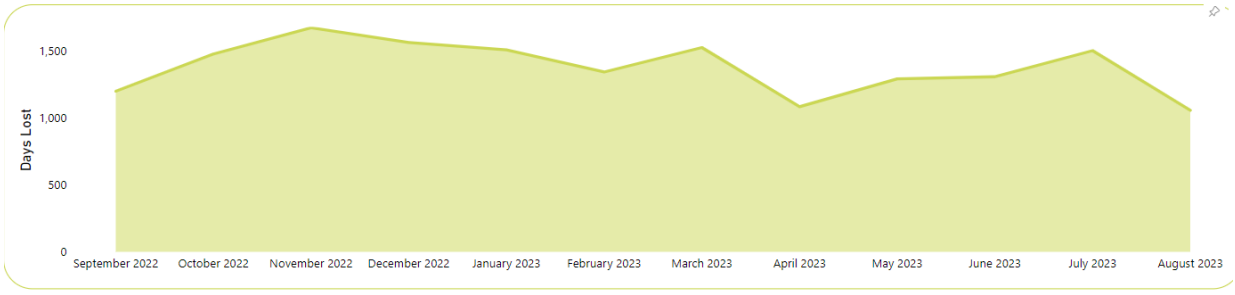
This is shown below in the graph showing days lost.



The main reasons for absence are shown below and have remained constant.



The reported incidents of anxiety and stress had increased slightly over the previous months, but this has decreased over the last month, as shown in the graph below.



Employee Relations

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

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

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

During 2022 HCS had a total of 25 disciplinary cases (of which 13 were suspensions) and nine grievances.

Staff Appraisal and Development

The data on the usage on Connected performance is shown in the summary table at the beginning of this report and shows that only 6.8% of HCS workforce have had their mid-year review and 9.9% have had their objectives approved by their manager.

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

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

- A performance management workshop - face to face training on how to have meaningful performance conversations.
- Connected performance espresso virtual sessions – virtual sessions on performance management process and line manager responsibilities.
- Creating a performance culture workshop – half day face to face session on performance management
- Bespoke system throughs – available on request, 1:1 or team training

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

Trajectories will be set for the delivery mid-year and end of year reviews and monitored via Care Group Performance Review meetings and into Executive Leadership Team and Board.

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Serious Incidents		
Report author (& title):	Andrea Bowring Lead Quality and Safety Manager	**Accountable Executive:**	Mr Patrick Armstrong Group Medical Director

1. Purpose

What is the purpose of this report?	The board is being made aware of the current serious incident investigation activity and challenges.	Information	x
		Decision	x
		Assurance	x
What is being asked of Board? *(brief statement & tick as appropriate)* *Any pre-reading*	The Board is being asked to note that the Senior Leadership Team (SLT) will be asked to consider a proposal that two Lead Nurses or equivalent posts are created to carry out investigations. These posts will support learning from incidents and carry out vital patient safety work.	Update	x

2. Executive Summary

- Health and Community Services have **41** Serious Incidents (SI's) currently open.
- There are **seven** SI's that have no investigator allocated. The longest open without an investigator is two months.
- A new process has been implemented to improve the governance of SI's.
- The Quality and Safety Team struggle to assign investigators to current open SI's.
- Serious Incidents are not being completed in a timely manner or within policy timeframes.
- The Quality and Safety team oversee investigations that do not sit under the remit of HCS, for example the Ambulance Service and Child and Adolescent Mental Health Services (CAMHS).

3. Finance / workforce implications

- The SLT agreed to offer investigators protected time to carry out investigations. If investigators require time from clinical duties, this request would be made to the Chief of Staff for that area or Lead Nurse. This has not currently been utilized as at the point of appointing SI's, clinical commitments, theatre schedules, clinics and off duty is already completed 6-10 weeks in advance and therefore being released is an

additional challenge of having someone to cover.
- Time built into job plans for doctors and nurses, to provide availability to complete SI's.
- Additional training is being organized.
- HCS SLT will be asked to consider giving trained investigators a one-off payment to complete an investigation.

4. Risk and issues

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

5. Applicability to Ministerial Plan

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

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

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

6. Main Report

Since Quarter 1 2023, the Quality and Safety team have continued to strive to work in collaboration with the Care Groups to increase the focus on patient safety and to share learning from patient safety incidents.

During Quarter 1 and Quarter 2 of 2023, the Quality and Safety team supported the Care Groups to facilitate 35 Safety Huddles.

To date, there have been 33 Serious Incidents commissioned in 2023 (as of September 15, 2023).

The Quality and Safety team review all safety events that have been coded as moderate and above on a weekly basis and support the care group to ensure the safety events are reviewed, actioned on and investigated. Monthly meetings are held with the Lead Nurses to discuss overdue Patient Safety Incidents and to discuss safety events graded as moderate and above. The Datix manager also offers support to the Lead Nurses to assist with this process.

During Quarter 1 and 2 of 2023, 104 staff received Datix training.

In Quarter 2, the Quality and Risk committee was presented with a paper for information purposes outlining the new process that had been approved by the Executive Leadership Team/ Senior Leadership Team (ELT/SLT). This paper identified existing difficulties in the

current SI process resulting in HCS not meeting its standards for completing investigations and not being able to provide assurance that lessons are being learned, actions completed, and risks reduced.

The change to the system increased the frequency and structure of the meetings and the lines of accountability. The need for action plans to be presented with the final report ensures that from approval, a more robust process is in place for monitoring of the recommendations by the Quality and Safety Team. The new process aims to ensure that patient safety and organisational reputation remains paramount. From September 15th, 2023, the length of the weekly SI meetings has increased from one hour to two hours. This allows enough time for detailed discussion of cases presented to panel and to ensure oversight of the SI process.

As sourcing investigators has become an increasing challenge, in August 2023, 13 staff undertook Root Cause Analysis training and further training is being organised. Sourcing local or national external investigators who have the capacity to carry out detailed and expert investigations in a timely manner remains a challenge to the Quality and Safety team, as can be seen in the below table.

The Lead Quality and Safety Manager and Head of Quality Improvement have been collating all outstanding serious incident recommendations. Meetings have been held with Care Group Leads in three of the care groups to-date to cleanse the data and establish outstanding actions. These actions are then being allocated an owner and handler. Outstanding care groups have meetings arranged and follow up meetings with the leads are planned over the next couple of weeks to try and gain further evidence of learning following SI's.

Care Groups	Number of SI's open	Time since SI's have been declared	Number of SI's without an investigator
Medical CG	12	2 x 17 months 1 x 15 months 1 x 10 months 1 x 6 months 1 x 4 months 1 x 3 months 1 x 2 months 2 x <1 month 1 x 1 week	12 open SI's is an increase of 4 since last reporting date. Without investigators: • 1 open 1 week • 1 open 2 weeks • 1 open 3 weeks
Mental Health CG	9	2 x 13 months 1 x 10 months 3 x 6 months 1 x 4 months 2 x 2 month	9 open SI's remains constant since last reporting date. Without investigators: • 1 open 2 months (have 1 investigator, no medic sourced from MH)
Women's and Children's CG	11	1 x 9 months 4 x 4 months 1 x 3 months 2 x 2 months 3 x <1 month	11 open SI's is an increase of 4 since last reporting date. Without investigators: • 3 open < 1 month
Surgical CG	4	1 x 13 months	4 remain open as per last reporting

		1 x 10 months 1 x 9 months 1 x 3 months	date.
Intermediate CG	1	1 x 1 month	
Joint Medical and Surgical CG	2	1 x 5 months 1 x 3 months	
Joint Mental Health and Ambulance CG	1	1 x 9 months	
Joint Medical and Mental Health CG	1	1 x 10 months	

7. Recommendation

In the past it was considered important that all senior staff completed SI training and investigations. The local picture is reflected across the NHS and this has become an increasing challenge. To mitigate this most NHS trusts now employ a team of investigators. Many trusts have now looked to a model where more senior investigators are appointed, they then become expert in the field of patient safety investigations and whilst still need expert medical and clinical input, this is more in a consultancy basis and less time consuming. They would be able to lead on the investigations fully and autonomously.

The SLT will be asked to consider the proposal which may include a request for funding for one lead nurse or health care professional of equivalent grade.

The SLT will be asked to consider whether one off payments will be offered to appropriately trained staff to carry out SI investigations.

It is essential that Doctors job planning includes time allocated to carry out investigations relevant to patient safety, including Serious Incidents, Thematic Reviews and Structured Judgement Reviews.

END OF REPORT

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Patient Experience Report - August 2023 activity		
Report author (& title):	Patient Experience Team	**Accountable Executive:**	Interim Chief Nurse

1. Purpose

What is the purpose of this report? What is being asked of th HCS Advisory Board?	The purpose of this report is to, - Provide an overview of all complaint / plaudit activity undertaken during this calendar year with a focused analysis on August 2023 complaints activity. - Highlight themes and trends and report on lessons learnt to improve the patient journey. - The report also provides assurance to the HCS Advisory Board that there is no consistency of individual staff members / time or clinical area related to the complaints reported. *For this report the term complaint covers all aspects of patient feedback*	Information	√
		Decision	
		Assurance	
		Update	

2. Executive Summary

This is the first report following the change in management structure. IT challenges within the month have prevented the production of monthly trend analysis however the number of complaints received during August remains consistent with other months. Focused attention has been placed on the early closure and resolution of complaints and Patient Advisory and Liaison Service (PALS) enquiries.

At the time of writing this report there has been a significant improvement in the closure of complaints. A verbal update will be given to the Board of the improved position against the August position.

The report has identified two key themes relating to complaints during August. Appointments were the 2nd highest category of complaint which can be explained by the opening of the new Enid Quenault Site as not all patients received letters about the change of venue for their appointments. This is now resolved. Patient and relatives have fed back through complaints and PALS concerns / confusion regarding Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) information. An ongoing education programme is underway.

Feedback regarding the ambulance services is no longer categorised under the medical care group as they have been assigned their own data set. Joint working will remain to ensure that learning across boundaries will be maintained and reported.

The report also provides assurance to the HCS Advisory Board that there is no consistency of

individual staff members / time or clinical area related to the complaints reported.

3. Finance / workforce implications

- Potential financial risk with complaints.
- Senior Nurse is now in post and the Head of Patient Experience is soon to be in post. The Chief Nurse care group has redirected staff from other teams to assist in investigating complaints.
- Training and Development required for Senior Nurse and incoming Head of Patient Experience.

4. Risk and issues

There is a continued need to improve the quality of the learning and dissemination to relevant parties. There also needs to be ratified policy of triangulation of complaints that allows for a more robust analysis.

There is a requirement for Care Groups to manage complaints in a timely and effective manner.

Learning from complaints and feedback is fundamental and is the best evidence for bringing about sustainable change and forms the basis for quality improvement (QI) projects related to patient experience. Therefore, assurance is required that HCS is undertaking a robust system of learning from feedback.

Early resolution of complaints remains the key priority. The team have recently reprioritised their workload, and the closure of 58 complaints within the month against a legacy closure of less than 10 per month. Priority work is underway to further improve the process for sharing learning from complaints and the achievement of sustained improvement.

5. Applicability to ministerial plan

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

6. Main Report

Appended.

7. Recommendation

The HCS Advisory Board is asked to,

- Note the contents of the report.

- Recognise the re-focussed working within the department to ensure timely resolution and closure of complaints.

END OF REPORT

Patient Experience Main Report

Total complaint activity year to date, including six legacy complaints received prior to January 2023.

Timescale	Total Complaints received
Jan 1st – Aug 31st 2023	315
August 1st – August 31st 2023	44

Total current open complaints from 2023 to 31st August 2023: 80

August 2023 Patient Experience Activity

Total New Complaints Logged	44
Total Complaints Closed	58
Total Compliments Logged	43
PALS Comments/Enquires logged	21
Support Line (Rheumatology Review)	42

Current open complaints by care group: 80 (Excludes the 6 legacy cases)

Care Group	Stage 1 open	Stage 2 open	Stage 3 open
Medical Care Group	23	2	0
Surgical Care Group	17	2	1
Women, Children and Family Care Group	12	0	0
Mental Health	13	1	0
Adult Social Care	4	0	1
PPI/Therapies	3	0	0
Non-Clinical Support Services	1	0	0
Total	**73**	**5**	**2**

Breakdown of August 2023 Complaints:

There were 44 complaints received during August. This is in line with the rolling monthly average.

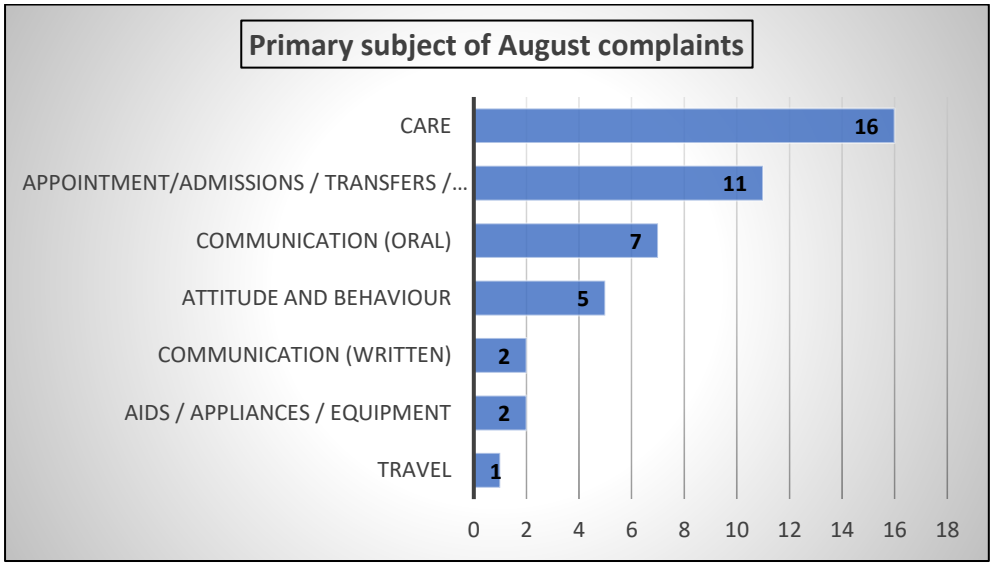
The '*care*' category remains the highest subject category with 16 complaints. This category includes the following criteria:

- Failure to undertake observations, tests, or examinations. (8)
- Medication issues (2)
- Concerns re diagnosis (5)
- Transfer time between different departments (1)

The second highest category received related to '*Appointments/Admissions/Transfers'.* This category includes the following criteria:

- Admission process
- Waiting times
- Delay in admission

Analysis of the above criteria highlighted that seven complaints were received in relation to waiting times. On further review there was no one area identified, and the complaints relate to a variety of areas where patients were waiting for appointments or tests.



August complaints by department:

The below table shows the complaints received in August split by department. In total 24 departments received complaints.

The Emergency Department (ED) and Rheumatology received the highest number of complaints, six and four respectively. *Care* was the highest primary subject for both the ED and Rheumatology complaints. On further analysis of the ED and Rheumatology complaints there was no one area identified, the complaints related to a variety of reasons.

Appointments were the 2nd highest category of complaint which can be explained by the opening of the new Enid Quenault Site as not all patients received letters about the change of venue for their appointments.

Department	# Logged	Department	# Logged
Emergency Department (ED)	6	Day Surgery	1
Rheumatology	6	General Medical Wards	1
Appointments	4	General Surgery	1
Surgical Wards	3	Gynae Theatre	1
Trauma and Orthopaedics	3	Learning Disability	1
Acute Assessment Unit (AAU)	2	Neurology	1
Diabetes and Endocrinology	2	Occupational Therapy - Overdale	1
ENT	2	Ophthalmology	1
Adult Community Mental Health Team	1	Pharmacy	1
Cardiology	1	Physiotherapy - General Hospital	1
Clinical Haematology	1	Radiology	1
Compliance and Sustainability	1	Travel Service	1

Open Legacy Complaints (6)

Care Group	open
Surgical Care Group	1
Mental Health	1
Medical Care Group	3
Adult Social Care	1
Total	**6**

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

- Waiting external investigation response (1)
- The complainant is under the management of the legal department. (3)

- Waiting internal independent review (1)
- Patient is unwell to support closure (1)

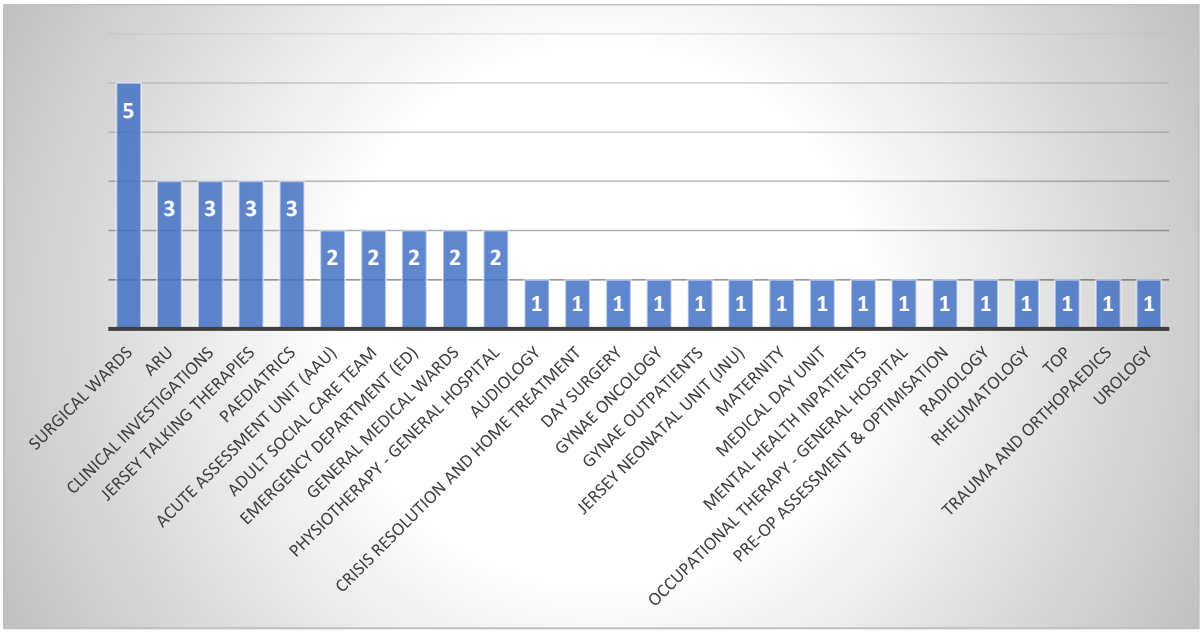
Whilst this is regrettable, there is ongoing communication with the families and additional face to face meetings have been established to ensure complainants are fully informed of the delay.

Plaudits /Compliments

Timescale	Total Compliments received
Jan 1st – Aug 31st 2023	553
August 1st – August 31st 2023	43

Compliments are categorised into three subject areas; '*staff attitude', 'thank you'* and '*care*'.

The chart below shows the compliments received during August 2023. Overall, 26 Departments received compliments, with the surgical wards receiving the highest number (6). 53% of all compliments received were logged under '*Care Provided'*.



Learning from feedback and quality assurance:

<u>My Experience survey results for August:</u>

20 responses received in total during August:

- The most common theme for patients who rated their experience as good or very good were '*staff attitude'* and '*care provided'*.
- One patient rated their experience '*very poor'*, and this was down to waiting times for an MRI scan.
-

The patient experience team are in final discussions with the Picker Institute to launch the independent anonymous survey of patient experience in the following areas by November 2023:

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

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

Workforce:

The team has encountered resignations in the past few months. A review of the department is underway, and the Chief Nurse care group has provided support to ensure the management of complaints remains a priority.

Training and education:

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

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

Lessons Learnt

Patient and relatives have fed back through complaints and PALS concerns / confusion regarding Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) information. Whilst significant information is available, the Resuscitation Manager has raised her concerns at the resuscitation committee and has a meeting arranged to discuss ongoing concerns with individual clinicians to identify any potential issues. The outcome of this will be cascaded throughout the care groups, shared with partner agencies and form part of ongoing education for all clinical staff.

Incorrect information on appointment letters as was reported earlier in the report, the original appointment letters did not provide the relocated clinic address information. This has now been resolved.

Moving Forward

Work is currently underway to establish key meetings where lessons learned captured through the analysis of feedback of complaints will be shared with all care groups, partner agencies to implement and monitor changes in practice.

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

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

HCS has not previously reported or established an independent process to identify if a complaint was upheld or not.

There remains a backlog of outstanding complaints which have not been completed within a timely manner. The new focussed approach to complaints management has seen a marked improvement in the outstanding complaints which will be reported at the next HCS Board

Complaints policy

The patient experience team are working closely with Customer and Local Services (CLS) to support HCS in achieving compliance with the customer feedback policy.

Conclusion

There have been significant changes in the leadership structure regarding patient experience. A review of processes has recently been reviewed ensuring the service provision is responsive to the needs of the population, demonstrates the opportunity for organisational learning and the embedding of new practice, which aligns with the government policy. The activity within September (to be reported verbally at the Board) reflects a positive improving trend, which will be further developed within future Board reports.

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Waiting List Report		
Report author (& title):	Andrew Carter, Head of Access	**Accountable Executive:**	Claire Thompson, Director of Clinical Services

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board?	To provide assurance regarding the waiting list position across outpatients, inpatients, and diagnostics (excluding mental health services)	Information	x
		Decision	
		Assurance	x
		Update	

2. Executive Summary

HCS operates a volume based PTL (patient tracking/waiting list) system. This has been necessary due to a localised patient administration system which was not compliant with monitoring end to end pathway reporting, such as the mechanism to report waiting list management as seen in other healthcare systems (e.g., UK).

The report describes the current waiting list position in relation to wait for first patient outpatient appointment, wait for elective surgery and diagnostic appointments. The Board will note the reducing position in OPA (outpatient activity) waiting times prior to new electronic patient record (EPR) in May and impact from increase in referrals at the end of Q1 2023. The static, minimal increase in elective waiting list position across the same period is noted and has been driven by steps to ring fence elective activity in patient area Q3 2022, limitations with bed capacity winter 2022/23 period and impact from activity catch in OPA converting to elective care.

The elective waiting list contains approximately 300 patients that were suspended from active PTL prior to Maxims go live and will be subject to same approach once functionality developed in Maxims. In addition to other cohorts of patients that will be subject to validation process which will reduce the PTL further in the upcoming weeks.

3. Finance / workforce implications

Challenge to recovery of some pathways/access to treatment continues to be affected by key vacancies e.g., dermatology, gastroenterology and respiratory. Whilst success is realised

through temporary recruitment at times, HCS observes speciality challenges as seen internationally. This in term drives agency spend and opportunities to drive sustainable, improved access targets and continuity of care for patients and team development. This has driven the need to consider alternative mechanisms to reduce the waiting list such as insourcing and outsourcing as examples. However, some of this allows the consideration of modernise and review existing pathways of care e.g., community dental commission.

4. Risk and issues

The Implementation of the new system (Maxims) has had an impact on the total volume on the outpatient waiting list. This is due to the following reasons:

- A planned reduction in clinical activity in the weeks immediately following implementation.
- Increased scope of services across the system, e.g., Audiology. HCS is considering the opportunities to refine our standardized reporting and improve benchmarking of current specialties on the PTL as part of the review of our access policy.
- referrals being added to the system for different functions, e.g., referral to a consultant vs referral to fracture clinics/dressing clinics on separate referrals.
- 776 patients initial review has demonstrated these patients have had appointments in the past who post validation will be confirmed as treatment completed.
- 234 duplicate referrals for the same specialty since go live.

5. Applicability to ministerial plan

Improving access and ensuring timely, consistent care and treatment that delivers high quality clinical outcomes and good patient experience in central to the Health Ministerial priorities.

6. Main Report

Appended.

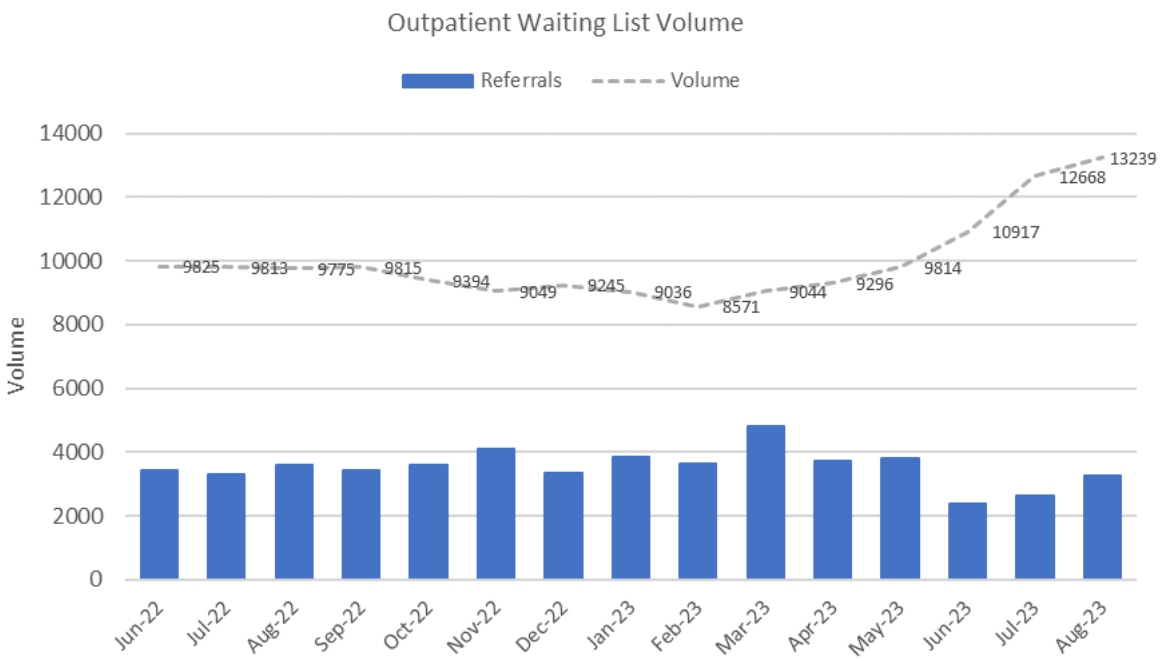
7. Recommendation

The board is asked to note the contents of this report.

END OF REPORT

Waiting Lists Main Report

Outpatients: Total Waiting List Volume



Urgent Position

- Total Volume, 962 Patients
- 0 > 52 weeks,
- 90 > 90 days.

Key Issues in relation to Urgent Position:

Dermatology – Total Patient Volume = 1240 of which 216 are on the Urgent Pathway.

30 Urgent patients waiting > 90 days.

- Service reduced to only one clinician in August 2023. Unable to recruit into second consultant post for 2 years. International shortage of locums, unable to fill via framework. Providers outside of framework in independent sector also unable to fill.

- Chief of Service in conversation with consultant team at Southampton. Activity to commence by end of October 2023, activity plan to be finalised progressing through medical staffing processes.

- £252,000 allocated to surgical care group from waiting list recovery plan to implement Teledermatology service. Stakeholder mapping meeting and initial procurement strategy meeting 20/09/2023. Intended outcome 30% of all referrals returned to primary care post virtual review. Access to advice and guidance within 48 hours from uploading image.

General Surgery – Total Patient Volume 836 of which 154 are on the Urgent Pathway

17 Urgent patients waiting >90 days.

- All longest waiting patients have failed to return a Faecal Immunochemical Test (FIT) to the department. Repeat tests have all been sent to the patients. If a repeat test is not returned to the department, they will be given a face-to-face appointment.

- FIT testing programme moving into primary care in Q4 2023. Secondary care will only accept referrals from Primary Care if the patient is FIT positive. Excludes pathways outside of FIT programme.

>52 Week Waiters – August Position, 912 in Total (0 Urgent, 4 Soon, 908 Routine)

52-week waiters triaged as Soon (4):

1 x Dermatology: Patient Did Not Attend (DNA) Feb 2023, Patient Cancelled May 2023, re-booked October 2023

3 x Ophthalmology: All booked, 10/10/2023, 27/10/2023 & 08/11/2023.

52-week waiters triaged as Routine (908), 856 of which are in three specialities as below:

359 > 52-week waiters in Ophthalmology = 90% of patients in this category are awaiting cataract assessment.

Actions:

- £989,980 allocated to outsourcing 500 cataract patients to provider in United Kingdom.
- Capability Assessment sent out to market; six providers opted into support.

- First draft of specification completed.
- Market engagement questionnaire to be shared with suppliers, being led by clinical lead. To be shared with supplier's w/c 02nd October.
- Activity to commence Q1 2024.
- Approach to recovery will assess a community follow-up pathway for cataract patients, to free up capacity within department.
- Decrease RAC clinics and ringfence a weekly cataract clinic.
- New middle grade commencing in post November 2023 so medical workforce will be at full establishment.

348 > 52-week waiters in Community Health Services Dental.

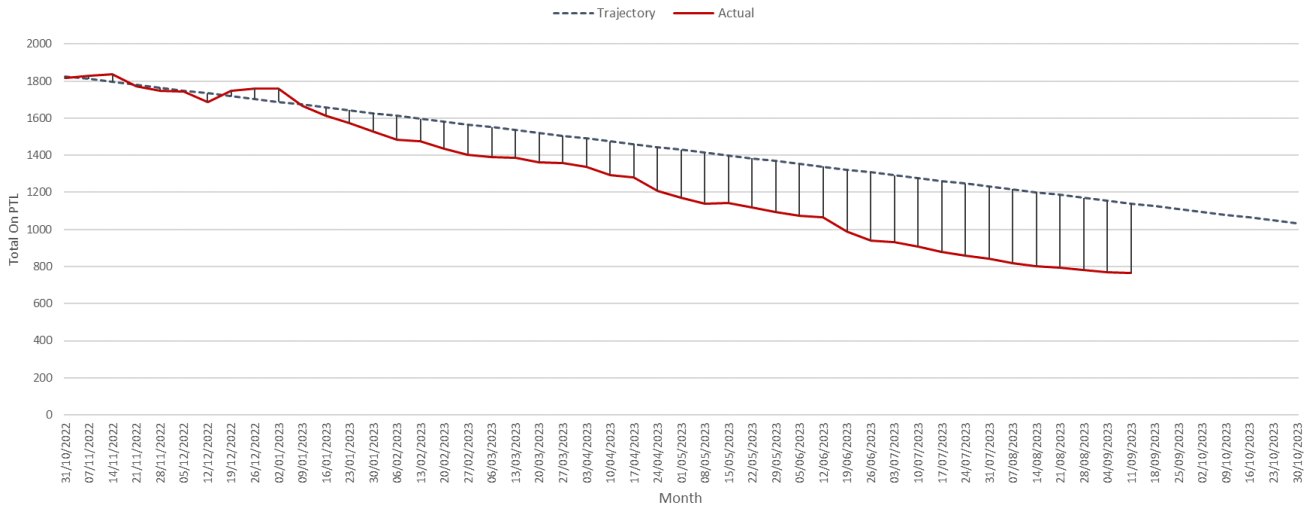
Recovery plan in place since October 2022, Commission of on-island dental practices to complete routine assessments and any initial treatment to get patients dentally fit.

PTL reduced by 1059 patients since October 2022 (-57.9%)

Scheme in place until the end of 2023. Please see performance against recovery trajectory in Appendix 1.

Oral Health Strategy to inform future of service post end of scheme.

Figure 1- Dental Commissioning Scheme performance against trajectory.



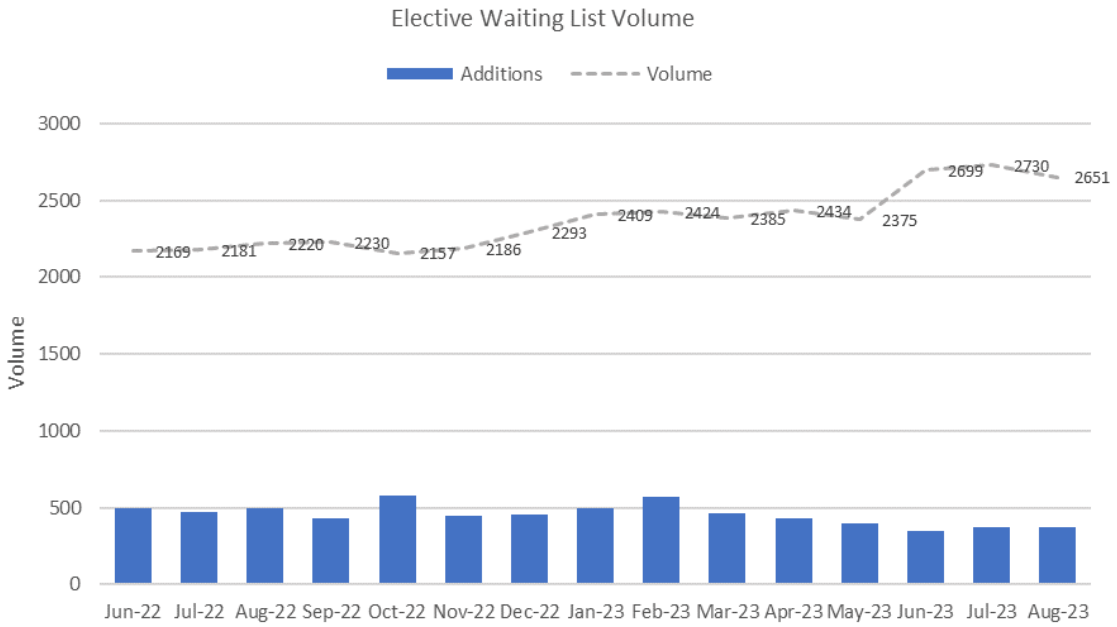
139 > 52-week waiters in Clinical Genetics

Service Level Agreement (SLA) in place with Guys and St. Thomas hospital until end of September 2023 for breast family history. Service Lead finalising outcome information from 50 patients on the PTL due week ending 17/09/23.

Various contracts in place off-island for various conditions.

Strategy submitted by service leads, requiring investment to implement the use of triage software and align to one accredited centre for most of the speciality. Approach in principle agreed by Senior Leadership Team, funding still to be ratified.

Inpatients:



Post implementation of Maxims (the new Electronic Patient Record system) it is not possible to separate the suspended patients on the inpatient PTL from the active patients. As part of HCS's access policy it is possible to suspend patients on the elective waiting list for social reasons / if they are not fit for surgery, HCS is working with Maxims directly and the EPR team to separate these patients from the active waiting list and will report on progress at next month's report (as previously managed in Trakcare). At go live there were 320 patients on the suspended list, the step change in the figure above accounts for this.

Current Waiting List Volume = 2651

>52-week waiters = 305 but majority are suspended patients unable to report exact figures until solution realised.

6 52-week waiters are urgent, 3 are on suspended pathways due to social reasons (patient choice). 1 has a TCI date and the remaining 2 are longest waiters for lower limb surgery. PTL oversight meetings will ensure these patients are listed in month.

46 > 52-week waiters are prioritised as soon patients within General Surgery and Trauma and Orthopaedics. 30 are on suspended pathways and 10 have TCI dates.

249 > 52-week waiters are prioritised as routine across Trauma and Orthopaedics, General Surgery and Ophthalmology and Ear, Nose and Throat.

Actions to address:

- Weekly TCI meetings led by Head of Access, check and challenge against PTL in line with access rule, book by clinical priority and then treat in turn.
- Monday scheduling meetings with TCI office, check and challenge re: scheduling and utilisation.
- Weekly 6-4-2 meeting to ensure actions are followed through, rotas are available 6 weeks in advance and ensure next 2 weeks scheduled is maximised.
- Oversight from Director of Clinical Services

Scheduling and booking: The implementation of the new system (MAXIMS) provides reporting which was previously unavailable in Trakcare. A dashboard has been created to support the scheduling and booking process which looks at the patients booked in the next 6 weeks and calculates the planned utilisation (based on how long the clinician has estimated the procedure will take) and predicted utilisation (based upon the average time it has taken the clinician to complete the procedure). This is being used in the scheduling meetings to challenge the weeks ahead and further populate lists, based on data and not historical practice / opinion.

The target for in-session utilisation is 85%with HCS achieving between 60%-70% across the majority of specialities. The impact for example in Ophthalmology would be to increase the average cases per session from 4.3 to >6. Across our Ophthalmic three surgeons this would create capacity to see an additional 214 annually.

Procedures on Limited Clinical Value (POLCV): A policy has been submitted to SLT for a decision regarding POLCV. It is estimated that 5% of public operations fall within the policy and would no longer be listed for surgery publicly. This item is a key deliverable of the Financial Recovery Plan.

Use of the independent sector / Waiting List Initiatives: £5million of investment has been allocated to HCS following an in-year business case to assist with waiting list recovery.

Diagnostics

Since the implementation of the new EPR it is not currently possible to report on the total volume of patients on the diagnostic Patient Tracking List except for Endoscopy. This is due to historic, standalone speciality activity systems regarding some diagnostic modalities e.g., x-ray, CT CRIS, Clinical investigations SOLUS. Although measures had been put in place to allow these systems to communicate with Trakcare, this has not been developed yet for Maxims. Unable to pull this data via informatics currently to allow quality assurance and integrated reporting.

Endoscopy: 1116 patients on PTL, 227 > 52 weeks. (351 Urgent)

- Service Level Agreement with Xyla elective care to complete 16 weekends of activity at weekends signed in August 2023.
- Provider will schedule 104 JAG points (1 point = 15 minutes to theatre time) of activity each weekend. (approx. 48 patients per weekend)
- First weekend of scoping to commence 07th October 2023.
- Pre-assessment of patients commenced August 2023.

The implementation of Maxims provides HCS with a Commissioning Data Set (CDS) compliant patient administration system. As such it will be possible to report standards in line with the NHS such as Referral to Treatment (RTT). However, Jersey may wish to have its own standards in relation to access. Immediate focus is on confirming the validation position following Maxims implementation, embedding new process and protocols, and delivering the waiting list initiative schemes to improve access to treatment for patients.

Report to: *(delete as appropriate)*	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4 October 2023		
Title of paper:	Consultant and SAS Doctors Job Planning Cycle 2023/24		
Report author (& title):	Jane Salzer Interim Head of Medical Staffing	**Sponsor (incl. Title):**	Mr Patrick Armstrong Group Medical Director

1. Purpose

What is the purpose of this report? What is being asked of the Board? *(brief statement & tick as appropriate)* *Any pre-reading*	Update to the Board on progress to date on job planning for Consultant and SAS Doctors To support the Group Medical Director in achieving full compliance with the contractual obligations for Consultants and SAS Doctors to have an up-to-date job plan	Information	✓
		Decision	
		Assurance	✓
		Update	✓

2. Executive Summary

Consultants and SAS Doctors are required under their Terms and Conditions of their employment contracts to have an annual Job Plan review. The job planning policy was ratified by the Joint Local Negotiating Committee on 8 December 2022. The organisation uses Allocate Job Planning as the IT system to assist doctors and line managers to complete their job plans and it acts as a repository for holding job plans. Reports on progress can be generated from Allocate to inform the Board of progress made. There are sufficient licences to allow all doctors who require a job plan to utilise the job planning module.

Chiefs of Service have made this a priority to complete the job planning round. It is recognised that intensive support is required to complete the job plans in a timely manner. A deadline of 14 September 2023 was set for completion of the job planning round. This deadline was not met (see figures for completion). This is mostly due to additional support needed to assist SAS doctors and support for Obstetrics and Gynaecology. The Deputy Medical Director will work with the Head of Medical Staffing to contact each Clinical Lead and offer additional assistance over the next few weeks.

A two weekly job planning consistency panel has been established being chaired by Professor Simon MacKenzie to provide assurance that job planning across HCS is to a consistent high standard and that reward for similar activities are equitable across the organisation.

3. Finance / workforce implications

Value for Money not achieved as difficult to reduce costs without agreeing job plans.

Low morale as some doctors are keen to have their job plans reviewed. There will be financial gains and losses for staff, however the job plans will more accurately reflect their contribution to the service.

Out of date job plans do not accurately reflect the work that our doctors are delivering for the service. Potentially inefficient utilisation of medical workforce.

Improved healthcare outcomes for Islanders as efficient use of substantive staff will reduce reliance on temporary locum cover and will provide better continuity of care.

Completion of job plans will result in improved morale of medical staff and assist with recruitment and retention as the job plans will more accurately reflect the medical staff contribution.

4. Risk and issues

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

Identified inconsistencies in reward for similar activities may take some time to resolve. For example, different reward for doctors on similar rotas working at similar levels of seniority. These issues will be discussed at the next Job Planning Consistency Panel.

5. Applicability to ministerial plan

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

6. Main Report *

There are 150 job plans active at varying stages on the Allocate system, since the system has been cleansed of leavers and test patterns. There remains a significant amount of work to do to achieve 100% sign off ahead of consistency assurance and final lock down. However very good progress has been made on the signed off job plans, an increase of 36 since the last report. (If this figure included Doctors who were previously in the signed off category but have now returned to the in-discussion category as they have started next year’s job planning round, the increase would be 49).

The Emergency Department (ED) have completed job planning meetings with consultants and their SAS doctors for the current year and have commenced a second round of prospective job plans for 2024; this is exemplar.

Adult Mental Health have also made excellent progress with final sign off required for the Clinical Leads' job plans to achieve final sign off.

Anaesthetics are continuing to work with their consultants to agree a final job plan, this should be completed by end of September 2023.

The British Medical Association (BMA) have delivered job planning training to medical managers to support the organisation in achieving compliance with terms and conditions of service for Consultants and SAS doctors.

The interim Chief of Service for Women, Children and Family Care Group (WaCs) has taken over the responsibility for job planning in WaCs from the Group Medical Director.

Progress made to 25th September 2023

August 2023

Signed off	12% (20)
Locked Down	0%
Awaiting 2nd sign off	7% (11)
Awaiting 1st sign off (By Doctor or Manager)	23% (39)
In Discussion	54% (89)
Expired job plans	2% (4)
Not Published	4% (7)

21 September 2023

Signed off	37% (56)
Locked Down	0% (0)
Awaiting 2nd sign off	0% (0)
Awaiting 1st sign off (By Doctor or Manager)	22% (29)
In Discussion	43% (65)
Expired job plans	0% (0)
Not Published	0% (0)

*It should be noted that 13 Job plans for ED Doctors that were in the signed-off category in August 2023 have now moved to the in-discussion category. This is because they have entered their next year's job planning round. These Doctors do have in date Job Plans.

7. Recommendation

The HCS Advisory Board are requested to note this update, and to provide ongoing support for

the Job Planning Cycle for Consultants and SAS Doctors.

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	National Institute for Health and Care Institute (NICE) Guidance		
Report author (& title):	Pam Le Sueur, Acting Head of Quality and Safety	**Sponsor (incl. Title):**	Mr Patrick Armstrong Group Medical Director

1. Purpose

What is the purpose of this report? What is being asked of the Advisory Board?	To provide an oversight of the current process around NICE guidance.	Information	x
		Decision	
		Assurance	x
		Update	x

2. Executive Summary

The Senior Leadership Team (SLT) agreed that HCS would adopt the National Institute for Health and Care Institute (NICE) guidelines in May 2023. The framework policy was ratified by the Policy and Procedures Ratifying Group (PPRG) in June 2023 and implemented in July 2023.

3. Finance / workforce implications

There has not been any current scoping carried out to establish whether NICE guidance is currently being used within HCS. Any additional resource that may be required to carry out this scoping exercise and identify where HCS is not compliant will be considered by the SLT.

4. Risk and issues

Risk ID 1305 - HCS cannot demonstrate compliance with NICE guidelines following the decision by the SLT to adopt these across HCS in May 2023.

5. Applicability to Ministerial Plan

This paper relates to the Minister for Health and Social Services 2023 Delivery plan,

specifically-

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

MHSS P3b.2. Overseeing continued development of services that will: - see the introduction of evidence-based standards of care.

6. Main Report

The Compliance and Assurance team that is being recruited to later this year will be able to complete the scoping work and gather the evidence of compliance with NICE guidance from Q1 2024. This is anticipated to take 6 months from the point of the team being appointed. Having policies and procedures up to date in line with best practice national guidance will be essential preparation for inspection.

As the scoping exercise has not been undertaken, HCS is not aware where NICE is currently being used in all clinical areas. We are currently reliant on care groups or individual clinicians volunteering this information. As NICE publish new guidance, updates, or exemptions are completed and approved. NICE have some clinical guidelines that are over three years old, this means it will be difficult to be fully assured that NICE guidance is being adopted across HCS in a timely manner.

To mitigate this risk, the Quality and Safety Team will be seeking assurance from the care groups that work is being completed within their areas as part of the newly established Care Group Governance meetings. A proforma is available for clinicians to use to capture where they are using NICE guidance, Chiefs of Service will be requested to ask their clinical areas to complete the documentation and send it back to the Q&S team, where a register of NICE guidance currently being used will be held.

The Quality and Safety Manager for Policy and Quality Improvement receives all notifications from NICE and sends new guidance out to the Care Group leads as appropriate. Care Groups are then expected to nominate somebody to update the policy and liaise with the Q&S Manager for Policy to ensure that new guidance is drafted, ratified and implemented within 6 months of publication.

When policies are being sent to Procedure Ratifying Group (PPRG) for ratification, the author will be asked to complete a form asking if this relates to any relevant NICE guidance, if NICE guidance exists and is not being followed an exemption will be required and this will need to be approved before the policy can be sent for ratification. The Q&S Manager for Policy will check this to ensure that no policies are being presented to PPRG that are not NICE compliant. The policy can then be added to the database of compliance with NICE guidance.

Since the SLT agreed to adopt NICE guidance, two exemptions to NICE guidance forms have been completed from the Medical Care Group. In line with the policy, the clinical area completes the form, which is sent to the Q&S Manager for Policy. This is then checked and approved by the relevant Chief of Service for that area and once agreed, sent to the Head of Quality and Safety who establishes whether further consultation is required with other clinical

areas impacted before sending it through for final approval to the Medical Director. A quarterly report detailing all exemptions will be presented to the Board.

7. Recommendations

To note the report and support the proposed plan of work.

To agree the quarterly reporting of all exemptions to the Board.

END OF REPORT

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Acute Internal Medicine Service		
Report author:	Dr Adrian Noon, Chief of Service.	**Sponsor:**	Claire Thompson, Director of Clinical Services

1. Purpose

What is the purpose of this report? What is being asked of the Board?	To inform the Board of the shared position of the Executive Team and the Change Team on this service and seek support for the proposed actions to improve the service.	Information	X
		Decision	
		Assurance	X
		Update	

2. Executive Summary

The current quality of care within the medical wards at HCS requires improvement. This is the view of the Leadership Team and evidenced by external reports. In addition, medical patients are occupying an increased number of beds which is impacting on the ability to provide surgical care.

The paper describes a future vision for inpatient medical care, acute internal medicine, which is based on evidence and tailored to the local needs.

Work to deliver this vision has already started but is far from complete. The problems were documented in 2014, the changes required are significant and will take time. Many of the actions are within the direct control of HCS and will require clinical and managerial commitment. A key part of the plan is greater consultant involvement, and this will require investment. A business case for this will be submitted.

There are some challenges, such as ensuring prompt discharge when patients are ready, that cannot be delivered by HCS alone and will require action jointly with providers of community care.

3. Finance / workforce implications

There would be costs associated with implementing a new model because of additional workforce, particularly consultant physicians.

4. Risk and issues

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

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

5. Applicability to ministerial plan

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

6. Main Report

Acute internal medicine is the term now used for the urgent and emergency care provided to patients requiring inpatient care, whether in assessment units or wards, for medical conditions. Most is provided in Jersey General Hospital, only a minority of patients require transfer elsewhere for specialist services.

Present quality of care.

Several reports (Royal College of Physicians (RCP) 2014, Review of Clinical Governance 2022, RCP 2023) have raised very similar concerns about the quality of care. These are attached as appendices. Review of Serious Incidents (SIs) corroborates the concerns.

The RCP 2023 said, '*Whilst the initial care of the patient was considered 'good care' by the review team, the care received after 24-72 hours (post-admission) was considered mostly 'poor care'.*

The identified problems include:

- Lack of consistent consultant ward rounds both during the working week and particularly at weekends. Limited support for junior medical and nursing staff.
- Lack of systematic ongoing review, refinement of the patient's diagnosis and management strategy.
- Failure to act on changes in patients' clinical parameters.
- Significant reliance on locum consultants for ward cover with established consultants disproportionately focused on specialist outpatient work.
- Acute Assessment Unit (AAU) trying to fulfil competing roles, acting as an assessment unit, enhanced care area, and as a ward. Patients should stay in AAU a maximum of 48 hours but may stay many days.
- Poor discharge processes for both simple and complex patients.
- Increasing mean length of stay resulting in excess bed requirements and patients outlying in surgical wards, with adverse consequences for both medical and surgical patients. Note however that RCP 2023 identified that some patients were discharged before they were fit.

The Executive Team and the Change Team agree that the standard of care currently provided is not acceptable and change is required.

Vision for the future

The Executive Team and the Change Team agree that the service needs an updated model with much greater consultant involvement and a focus on active planning for discharge from early in admission. The recommendations of the RCP report have been accepted.

There are well established guidelines on the management of acute internal medicine including from the RCP, Getting It Right First Time (GIRFT) and NICE. These, combined with the specific recommendations in the RCP review of Jersey General Hospital, will form the basis for the future state.

More detail is available in the appendices, but the initial improvement focus is on the following:

AAU is an admission and assessment unit. It must adhere to a maximum stay of 48 hours and if it is clear that a patient will need a longer stay then they should be transferred to the appropriate ward as soon as possible. It should be appropriately sized to manage admissions with a maximum planned 80% occupancy. In practice this means all 25 physical spaces.

Same Day Emergency Care (SDEC) needs to move from its current poorly located and unsuitable accommodation. A location needs to be agreed.

Enhanced Care Area (ECA) needs an agreed care model.
Most admissions are for cardiac or respiratory monitoring and support. A clinical group including acute medicine, cardiology, critical care, and respiratory departments has been established to agree a model.

Base medical wards.
An increase in medical ward beds is required and an options paper was submitted to the Senior Leadership Team (SLT) for discussion on 21st September 2023. This was approved and a detailed action plan is in development to implement.

Consultants should participate in both inpatient care and out of hours cover. Out of hours cover for both AAU and base wards must be consistent and a core part of job plans, not an option. This is likely to require in the region of 16 consultants to allow one to cover AAU and one the base wards on two 1 in 8 rotas with prospective cover. The primary commitment to general medicine needs to be restated. Consultants should not practice in isolation. All sub-specialities should have a minimum of two consultants and an established relationship with a specialist centre for both continuing professional development and MDT working. This will require the creation of additional consultant posts. This will significantly improve the quality of care. The dependence on locums must cease on both quality and financial grounds. There is a clear need for appointments in geriatrics, respiratory and gastroenterology.

Flow and capacity management
As a small hospital Jersey General Hospital is more vulnerable to relatively small random variations in admission and discharge. We need to plan for a lower bed occupancy than a larger hospital would, particularly in admission areas. Flow management will be embedded and there needs to be senior management of the whole hospital and ideally all HCS. This will be the Director of Clinical Services but depends critically on medical (including surgical) and nursing staff so both Medical Director and Chief Nurse will be involved. They need to redesign the system to avoid crises and be present to directly manage these when they occur. The working day, ward rounds and actions arising need to be focused on discharge

early in the day. This will require support from pharmacy, radiology and allied health professionals. This needs to be 7 days per week.

Timely and focused care
Based on evidence from other services, discharge planning will start at admission with a focus on getting people well enough to return home. Necessary specialist opinions, investigations and procedures will be delivered quickly but people will not be kept in hospital for investigations or treatment of coincidental health issues which can be investigated as an outpatient.

Delayed Transfers of Care
Some of whom are from the start 'social admissions' only, admitted because of lack of alternative. This is not the only flow problem but the benefit of resolving it for the individuals, GoJ, HCS and other people who do need hospital care would be huge. For the patients who are stuck in hospital, a place few would choose and where their ability to care for themselves and have some independence will inevitably deteriorate. The GoJ ends up providing sub-optimal care (for these people's needs) in a particularly expensive way and because of this, patients who would benefit from hospital admission are denied it. This is an area where Jersey should explore the freedom of being a distinct jurisdiction to experiment with possible solutions. There are a range of options including enhanced community provision, setting up intermediate care, further nursing home provision through HCS.

Actions taken to date:

A plan to address the recommendations made by the RCP has been developed and progress will be monitored and managed through the Change Programme Board (CPB). The report has been shared with staff including two meetings with the consultant staff. These meetings produced further suggestions for improvement.

EPMA (Electronic Prescribing and Medicines Administration) has been rolled out across the service which addresses recommendations from the RCP 2022 report.

HCS has adopted NICE guidelines as our standard.

Medical staffing.
Key to our plan is a change in working practices and more consultant involvement in inpatient care.

- AAU now has consultant ward rounds seven days per week. Corbiere will receive daily ward rounds by an accredited frailty locum Consultant in October. Bartlett (respiratory ward) will be supported by 2 Consultant locums in respiratory medicine through internal efficiencies. Rozel now has daily ward rounds by virtue of a long-term locum appointment accredited in general medicine.
- Consultants and middle grade doctors have had job plan discussions and are in a process of sign off that will consider the future state to be achieved.
- 18 clinical fellows will be in post by the end of August. The Clinical Fellows have been added to an electronic health rota which has also been successfully implemented for FY1 and FY2. All shifts are single task i.e., Doctors are not on ward rounds whilst also having to cover the acute admissions, correcting a defect in the previous system.
- An education programme for Clinical Fellows, which will give assurance to patients, HCS Board and the Clinical Fellows themselves that they are achieving the outcomes set out in the four domains of Good Medical Practice. This curriculum will be delivered through

an induction programme, training carousel, monthly protected training afternoon, personal study leave and workplace-based assessments.

Nurse staffing.
We are conducting a review of nursing numbers in conjunction with the current bed model.

Next steps

Over 2023 and 2024 we will continue to implement the recommendations of the RCP 2022 report and deliver the vision outlined. We will embed the new practices on ward rounds to ensure that they deliver. An experienced consultant from another hospital will provide peer support. A key objective will be to stop and then reverse the increase in length of stay whilst ensuring that patients are not discharged before they are sufficiently well. This independent peer review has described positive, recent assessment of areas of practice including ED, AAU and vetting of agency staff to ensure high caliber appointments.

Reconfigure consultant workforce to conform to the vision for the future recognition of the focus on general medicine as the main inpatient activity with the correct balance of specialty interests to meet needs for inpatient, outpatient and diagnostic care. No consultant will work in isolation through a combination of local colleagues and opportunities for Jersey consultants to exchange with colleagues in other hospitals to maintain skills.

There is a need to appoint consultants in areas where Jersey presently has none, including geriatrics and stroke, and to strengthen other specialties. The current estimate is that between 10 and 12 new appointments are required: some mitigation may be possible by, for example, employing allied health professional (AHPs) and nurse practitioners to support outpatient work.

It is relevant that the medical care group has recently recruited three more Emergency Department (ED) consultants and 3 more middle grades. This has substantially improved patient care and reduced cost by replacing locums with substantive posts. As a result of these measures in ED, the Royal College of Emergency Medicine is now considering our application to be an approved trainer of middle grades (Around ST4 to ST6 level) as well as strengthening our Certificate of Eligibility for Specialist Registration (CESR) programme to produce our own consultants of the future. This shows that initiatives such as those proposed can not only improve quality but enhance recruitment in the longer term.

7. Recommendation

The Board is recommended to:

1. Endorse the assessment of the current quality as not acceptable.
2. Support, in principle, the plan to provide a modern consultant led service that is effective, efficient, safe, caring and focused on the needs of patients.
3. Acknowledge that this will require additional consultant posts and require investment.
4. Ask the executive team to progress the plans, including for workforce and a business case for investment and update the Board at the next meeting.

Appendix

RCP 2014

RCP 2022

END OF REPORT

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Women's and Children's Care Group		
Report author (& title):	Dr David Hopkins, Interim Chief of Service Women, Children and Family Care Group (WaCs)	**Accountable Executive:**	Claire Thompson, Director of Clinical Services

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board?	To update the Board on progress within the Care Group and in particular the Maternity Improvement Plan (MIP)	Information	x
		Decision	
		Assurance	x
		Update	

2. Executive Summary

Maternity services at HCS including neonatal care have been the subject of a series of external reviews over the last 5 years. Over the same period, several reviews of maternity services in the UK have been published which included recommendations of relevance to quality improvement in obstetric and maternity care (East Kent Report, Ockendon Report). The recommendations from these internal and external reports have now been collated into a comprehensive action plan (the Maternity Improvement Plan, MIP) with the aim of addressing all areas identified in a timely fashion and achieving sustained improvement in the quality of services over the following year. This report summarises the current position of this plan.

3. Finance / workforce implications

There are challenges in the recruitment and retention of clinical staff across the department which impacts on the process of embedding changes and results in significant cost pressures. Optimising substantive recruitment is being consider in the division's parallel Workforce Recovery Programme with the aim of reducing locum spend as well as improving quality. In parallel, long-term workforce strategy is being considered as part of the MIP. It is anticipated that some increase in workforce may be required to optimise services, and this is being formally tested with a validated external assessment (Birthrate Plus). Currently two consultant Obstetrician posts are covered by locum/agency doctors. There are 8 WTE (wholetime equivalent) midwifery vacancies and 5 are covered by long term agency with substantive midwives undertaking additional shifts.

4. Risk and issues

The highest risks relate to staffing of the maternity/paediatric service and the need for cultural improvement within the service. The MIP contains a series of recommendations relating to improving the culture and multi-professional relationships across the care group.

5. Applicability to ministerial plan

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

6. Main Report

The Maternity Improvement Programme was established on 28th June 2023, the purpose of the programme is to deliver coordinated and sustained improvements within Maternity to address the recommendations from both internal and external reviews which have received and been within the organisation since 2018. In addition, the MIP incorporates learning and recommendations from speciality best practice guidance such as Ockenden Report 2020 and 2022 and Kirkup 2022.

The status of progress of the MIP is presented below. All recommendations (131) have been mapped against five workstreams with the overall themes of Patient Transfer, Strategy, Performance, Governance and Workforce. The Executive Director's / Senior Responsible Officer (SRO) for those workstreams are described below:

- Workforce – Associate Director of People
- Governance – Medical Director
- Performance – Director of Clinical Services
- Strategy – Director of Clinical Services
- Transfer – Director of Clinical Services

The plan is managed by the Chief of Service and Director of Midwifery with support of a project manager and progress is reviewed weekly by an executive group chaired by the Medical Director with support from the Chief Nurse, Director of Clinical Services and relevant members of the Change Team. An external expert obstetrician has been engaged to advise on the programme of work and provide regular peer review scrutiny and expertise to the Interim Chief of Service. Progress has been made addressing the recommendations with the aim of bringing all elements into 'business as usual' over the course of the next year; it is anticipated that the majority will be closed by the end of 2023 with the notable exception of the cultural recommendations and whilst that work will be well established, cultural change is not a quick solution. This will be achieved through actions to improve standard clinical governance processes as well as individual improvement actions/specific tasks. The status of MIP as of 12 September 2023 is set out in a summary chart provided as an appendix to this report.

Progress to date on achieving the objectives of the MIP are described below:

Of the 131 recommendations which constitute the MIP, 53 have been achieved and identified as complete.

The areas of escalation relate to culture, training, standardised reporting and aspects of the gynaecology estate. It is anticipated that, apart from the cultural plan, all remaining areas of escalation are on track for completion by the end of September. (Appendix A). Appendix C

describes the new performance standardised maternity reporting template.

7. The key Issues

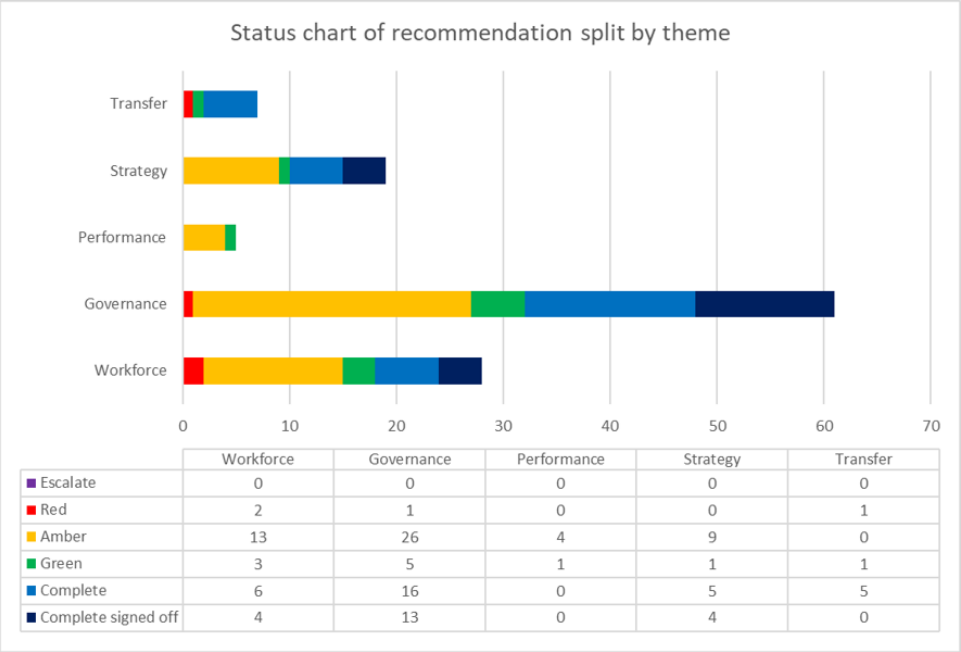
There is a need to maintain continuous improvement and progress with MIP and to ensure recommendations are embedded in the service. To this end, a weekly newsletter is produced for all staff to ensure all staff are aware of progress and are therefore able to comment and own the plan (Appendix B). A particular challenge that will be crucial to sustaining improvement is to achieve change in the culture of the department particularly in relation to effective multi professional working and this will be a major element of the next phase of the work on the MIP. The MIG (Maternity Improvement Group) will continue to meet weekly and provide assurance/escalations into the Change Programme Board chaired by the Chief Officer.

8. Recommendation

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

END OF REPORT

Appendix A: Status of Maternity Improvement Plan as of 20th September 2023



	Workforce	Governance	Performance	Strategy	Transfer
Escalate	0	0	0	0	0
Red	2	1	0	0	1
Amber	13	26	4	9	0
Green	3	5	1	1	1
Complete	6	16	0	5	5
Complete signed off	4	13	0	4	0

Escalate – To be escalated to MIG or WACs SLT
Red - Work to deliver against recommendation is off track and requires resource to mitigate.
Amber - Work to deliver against recommendation is off track but recoverable by operational lead.
Green - Work to deliver against recommendation is on track no escalation required, evidence is available to support this status.
Complete - The recommendation is considered complete; evidence is being gathered for approval by WACs SLT
Complete signed off - The recommendation is considered complete by WACs SLT with robust evidence and sustainability of BAU processes.

Health and Community Services

Health and Community Services Advisory Board Report

Appendix B

What has been completed so far?

The MIP includes 131 recommendations of which 58 have been completed, these achievements include:

- Ongoing Maternity Refurbishment
- Maternity Leadership team
- Midwife Specialist for Infant Feeding appointed
- Perinatal Mental Health Midwife appointed
- Improved access to breastfeeding support
- Improved governance through updated policies

Your voice

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

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

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

What is the Maternity Improvement Plan?

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

What does it mean to me?

The aim of the MIP is to:

- Demonstrate our provision of safe and caring services for women and their families
- Ensure staff are empowered to speak up
- Utilise data and benchmarks to provide assurance of our high quality service and drive improvements
- Evidence the care needs of patients will always come first
- Staff will be supported and valued for their contribution to high quality patient care
- Ensure transparency and learning from incidents is open

Maternity Improvement Plan

September 2023

Appendix C Maternity Dashboard

Clinical Performance Metric /Maternity Dashboard
Measure
Pre-term births (Under 37 weeks)
Neonatal Deaths (per 1,000)
Stillbirth (per 1,000)
HIE (per 1,000)
Transfer of care during pregnancy (planned)
Transfer mothers (inpatient)
Transfer of Neonates from SCBU
Placement on Continuity – Black/Asian Women
Placement on Continuity – Women in most deprived areas
Proportion of Mothers who were current smokers at booking appointment
Proportion of Mothers who were smoking at delivery
Proportion of Mothers who were consuming alcohol at booking appointment
Proportion of Mothers who were consuming alcohol at delivery
3rd/4th degree tears
PPH >= 1500ml
Apgar score <7
Spontaneous Delivery Rate
% LSCS at full dilatation (Lower uterine segment Caesarean section)
Rate of intrapartum stillbirth (per 1,000)
Admissions to Neonatal Unit >37 weeks (per 1,000)
% of women receiving 121 care (percentage) in Delivery Room
Rate total babies born midwife not present (per 1,000) (BBA)

% of live births less than 3rd centile delivered > 37+6 weeks (detected and undetected SGA)
Total number of deliveries before 27 weeks gestation
Booking < 70 days gestation

Amended High level dashboard amended from Liverpool Women's Hospital

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Infection Prevention and Control (IPAC)		
Report author (& title):	Dr Ivan Muscat, Director of Infection Prevention and Control and Janice Byrne, Interim Lead Nurse for Infection Prevention and Control	**Accountable Executive:**	Interim Chief Nurse, Jessie Marshall

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board?	To provide information and an update to the Advisory Board relating to Infection control practice within HCS.	Information	√
		Decision	
		Assurance	√
		Update	√

2. Executive Summary

To provide the Board with an overview of the IPAC activity within HCS. There were no outbreaks reported during August 2023.

3. Finance / workforce implications

Whilst this paper contains no financial implications, the average cost of each hospital acquired infection (HAI) is in the region of £3,500, with bacteraemia costing £ 20,000. The average increase in patient stay can be nine days as a result of poor infection control practice which reinforces not only the patient safety impact but also the consequential financial impact.

4. Risk and issues

Poor infection control compliance will lead to increased infection rates, increased length of stay, a poor patient experience and the risk of increasing drug multi resistant organisms. Therefore, strict adherence to all recognised IPAC regulations is mandatory.

5. Main Report

Health Care Associated (HCAI) Bacteraemia and Clostridium Difficille (C. diff) 2023

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
MRSA	0	0	0	0	0	0	0	0					
MSSA	0	0	1	1	1	0	0	1					
E Coli	0	0	0	1	1	0	1	0					
Klebsiella	0	0	1	0	0	0	0	0					
Pseudomonas	0	0	0	0	1	1	0	0					
C. diff	1	2	1	1	2	1	1	0					

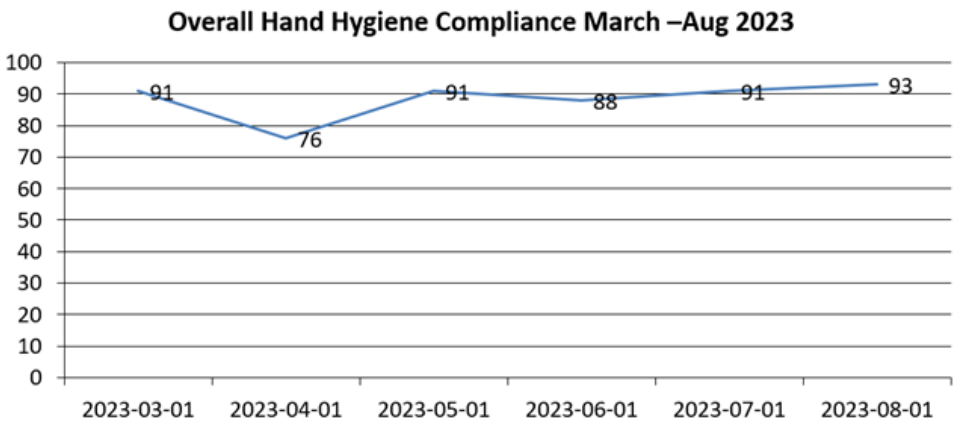
MRSA, MSSA, E Coli, Klebsiella and Pseudomonas all remain within last year's trajectory with no single ward or clinical area consistently reporting positive cases. Therefore, we can be confident there is no evidence to-date of cross infection or ward-to-ward transmission. There were no reported outbreaks during the month of August.

Whilst remaining within last year's trajectory, there was a three-month period of one ward experiencing four cases of Clostridium Difficile (C. diff). A robust infection control protocol was introduced e.g., pre-fogging protocol daily chlorine based clean of ward, sporicidal wipes all patient equipment including commodes and nightly UV each communal patient shared toilet. There have not been any further cases on this ward since June 2023. This is testament to the value and dedication of our housekeeping and clinical staff.

With the increase in seasonal activity, the organisation will have heightened awareness with regard to bed flow and the ability to vacate clinical areas to undertake recognised infection control decontamination.

Hand Hygiene Compliance by Health care professionals

Overall hand hygiene compliance has improved to 93.2% (90% compliance required) in August based on the World Health Organisation (WHO) 5 moments of hand hygiene. The last six months is shown below.



When clinical staff are identified as not being compliant with hand hygiene, discussions with professionals are undertaken at the time of observation. If a subsequent improvement is not noticed these matters are escalated to the chief of service, lead nurse or general manager. If non-compliance continues professionals will then be escalated to the medical director or chief nurse.

Flu and Covid staff vaccination programme is due to commence 25th September 2023.

6. Recommendation

The Board is asked to note the contents of this report to recognise the improvement in hand hygiene and ongoing infection control measures against the background of increased activity.

END OF REPORT

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Position paper outlining the minimum requirements to effect HCS compliance with statutory General Medical Council (GMC) Appraisal and Revalidation regulations for all doctors employed within the States of Jersey Employment Board Class (Medical Practitioners (Registration) (Responsible Officers) (Jersey) Order 2014)		
Report author (& title):	Dr John McInerney (GMC Suitable Person/Responsible Officer (RO)	**Accountable Executive:**	Mr Patrick Armstrong, Group Medical Director

1. Purpose

What is the purpose of this report? What is being asked of The Advisory Board?	1) To clarify the purpose of GMC Medical Appraisal and Revalidation. 2) To outline the legal framework and statutory basis of GMC regulation and licensing of doctors in Jersey. 3) To describe how HCS currently delivers via the HCS Appraisal and Revalidation policy 2022. 4) To explain the current shortfalls in assurance in HCS compliance. 5) To share solutions to overcome shortfalls and provide measurable assurance of improvement. A paper will be submitted to SLT to discuss the resources required and the Board will be updated once decisions have been made.	Information	x
		Decision	
		Assurance	
		Update	x

2. Executive Summary

Medical revalidation is a legal requirement, which applies to all licensed doctors listed on the General Medical Council (GMC) register in both the public and independent sectors in Jersey. Its purpose is to improve patient care by bringing all licensed doctors into a governed system that prioritises professional development and strengthens personal accountability.

Medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work.

Through effective appraisal, doctors demonstrate their professionalism, insight, and reflective practice.

Along with professional governance processes and management structures within organisations, where applicable, the outputs of appraisal assist the Suitable Person (SP) / Responsible Officer (RO) in making informed revalidation recommendations to the GMC about continued licencing to practice.

Employing or contracting organisations may describe additional information to be included in the appraisal portfolio for practical reasons. For example, they may want a doctor to demonstrate completion of a relevant element of mandatory or recommended training. This is normally an employment requirement and not required for revalidation.

Doctors, appraisers and responsible officers should be clear about the GMC requirements and should keep employment requirements and performance review separate from medical appraisal.

As part of the co-production with GMC Revalidation of the HCS Appraisal and Revalidation Policy 2022, an agreed suite of supporting metrics (HCS Portfolio of Evidence 2023) was proposed that HCS would collate and provide to all doctors and their appraisers, and this has been previously piloted successfully within HCS in 2019 prior to the COVID19 Pandemic. Unfortunately, since 2019 this information has only been provided ad hoc in appraisals (by individual doctors) due to lack of resource/capability within HCS to collate the required metrics.

The Professor Hugo Mascie-Taylor (HMT) report and subsequent #BeOurBest (BoB) Assurance Working Group has identified the continued shortfall in capture and recommended HCS collate these essential metrics to input as supporting information for annual appraisal.

Furthermore, this continued shortfall in appraisal input data has led to concerns that there is a lack of assurance around local clinical governance processes in sharing information about incidents that require reflection and agreed changes in practice within the annual appraisal process.

This proposal sets out solutions that can rectify the current gap in assurance and allow an enhancement of the current Appraisal system with measurable outputs elucidated by continuous quality assurance audit and support from an expanded Responsible Officer Advisory Group (ROAG).

3. Finance / workforce implications

There will be a staffing and time resource implication upon Health Informatics in terms of which metrics can be identified and collected from the MAXIMS IT system. The suite of activity metrics includes Dr Foster / GIRFT data as utilized in the NHS – activity, complications, unplanned returns, mortality, and audit attendance etc. for individual doctors (now more than 200 doctors on the SEB RO list). It would also necessitate doctor's collating private activity metrics at their own time and expense.

There may be IT investment or additional licenses needed to retrieve and share this data across either current or new IT platforms. Consultants with private activity could contribute to the cost by applying for a license to be given an annual report of this data set.

There will also be a staffing and time resource implication for the Quality and Safety team in terms of adapting the current Datix system to identify doctors involved in a complaint / compliment or safety incidents and collate and share this data annually and within 3 months of appraisals.

There is interest amongst suitable candidates to apply for the roles of Clinical Appraisal Lead / Deputy Responsible Officer which would require a one Programmed activity responsibility payment and locum backfill for two direct clinical care sessions per Deputy Responsible Officer begin with and allow development of a ROAG working resiliently with both the Secondary Care and Primary Care ROs. This additional Deputy RO would allow the current ROs to focus on other issues such as improved appointments process of permanent staff and onboarding of locums, dealing with concerns and new envisaged legislation around assisted dying for instance.

The current HCS Appraisal Manager role has to complement other HR duties, which entails less than 100% commitment to Appraisal and Revalidation. This role should focus exclusively on managing the appraisal system but would require further investment for Medical HR to cover other current duties.

The current Allocate Zircadian system has been in place for 10 years and is constantly causing issues with lost data, drop-outs and is not as fit for purpose as other systems e.g., Fourteen Fish which is used by Primary care. We need to review our contract as additional licenses, (from 150 to 200 in five years) have been very costly for no additional visible benefit. It would be preferable to host a competitive bid that allows better synergy between appraisal and job planning as a mid-term goal, with Fourteen Fish having financial cost advantage as already in place in Primary Care.

4. Risk and issues

This uplift in appointments also has raised the number of doctors requiring annual appraisal with a need to review our appraisal system and enhance quality assurance audit.

There are also increases in the whole scope of practice of local doctors and a requirement to improve the quality and quantum of supporting information inputs, e.g., novel low volume prescribing and interventions, medical cannabis prescribing, cosmesis practice, assisted dying legislation changes, which is also increasing the SP workload away from appraisal.

5. Applicability to ministerial plan

This proposal aligns and is fully congruent with the MHSS plan, which endorses the Professor Hugo Mascie-Taylor (HMT) report and wishes to enhance assurance and audit the whole Appraisal process in Jersey.

It also complements the need to reduce dependency in a safe manner on locum spend and improve retention and recruitment of Medical Staff to Jersey.

Good appraisal also supports good clinical governance systems and the wellbeing of the medical workforce, which augments the ministerial plan.

With the emergence of an inspection function of Jersey Care Commission (JCC), a good appraisal system that has measurable inputs/outputs will inform and assure local regulation and the GMC that doctors are keeping up to date and remain safe to practice.

6. Main Report

What is GMC revalidation and 'what is and what not' is medical appraisal?

Medical revalidation is a legal requirement, which applies to all licensed doctors listed on both the General Medical Council (GMC) and Jersey Care Commission (JCC) registers, in both the public and independent sectors in Jersey.

Its purpose is to improve patient care by bringing all licensed doctors into a governed system that prioritises professional development and strengthens personal accountability. The process is summative and is delivered by a single Suitable Person in Crown Dependencies like Jersey as set out in both GMC and Jersey Medical Act legislation 2014.

Meanwhile medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work.

It is developmental, formative in nature and should not be confused with other forms of corporate appraisal e.g., performance management.

Through effective appraisal, doctors demonstrate their professionalism, insight, and reflective practice.

Medical Appraisal has four purposes:

1. To enable doctors to enhance the quality of their professional work by planning their professional development.

2. To enable doctors to consider their own needs in planning their professional development.

3. To enable doctors to consider the priorities and requirements of the context(s) in which they are working.

4. To enable doctors to demonstrate that they continue to meet the principles and values set out in Good Medical Practice, and therefore inform the responsible officer's revalidation recommendation to the GMC.

Appraisal and clinical governance are distinct processes that work in synergy to demonstrate a doctor's fitness to practise and promote quality in the provision of patient care.

Primarily, the clinical governance process is where a doctor's professional actions are assessed; appraisal is the forum where the doctor demonstrates that they are keeping up to date and reflecting on what they do.

All information relevant to a doctor's fitness to practise from across their full scope of work should be available in both the doctor's appraisal and the designated body's clinical governance system.

Along with professional governance processes and management structures within organisations, where applicable, the outputs of appraisal assist the SP/RO in making informed revalidation recommendations to the GMC.

Employing or contracting organisations may describe additional information to be included in the appraisal portfolio for practical reasons. For example, they may want a doctor to demonstrate completion of a relevant element of mandatory or recommended training. This is normally an employment requirement and not required for revalidation.

Doctors, appraisers and responsible officers should be clear about the GMC requirements and should keep employment requirements and performance review separate from medical appraisal.

Legal responsibilities and escalation

A doctor must ensure that their appraisal inputs demonstrate fitness to practise across their scope of work.

The responsible officer must be assured that the doctor's appraisal inputs support a recommendation of fitness to practise. The appraiser provides this assurance to the RO via the appraisal outputs to make statutory revalidation recommendations to the GMC for continued licensing of the doctor.

Concerns about a doctor's practice must be included for reflection at appraisal. However, the prime purpose of doing so is to prompt reflection rather than judgement. The local management of a concern (including whether to involve the GMC) is the remit of the responsible officer.

A doctor should be provided by HCS with details of any concerns for presentation and reflection at appraisal.

The supporting information should relate to the doctor's complete scope and nature of work. The GMC describes six types of supporting information doctors must reflect on and discuss at their appraisal.

1. Continuing professional development (CPD)
2. Quality improvement activity (QIA)
3. Significant events or serious incidents
4. Feedback from patients or those they provide medical services to
5. Feedback from colleagues
6. Compliments and complaints.

The doctor and HCS share responsibility for gathering this information about the doctor's practice for overlapping reasons. Doctors and HCS should work constructively to achieve this in the interests of transparency and improving patient care, and of reducing the burden of documentation for doctors.

Obligations for HCS and doctors

Organisations where doctors are employed or work, where possible, support them in collecting and providing the GMC required supporting information. This adds objectivity to the information, supports organisational quality and reduces paperwork for the doctor.

There will always be some information that only the individual can provide, and some doctors who work outside any organisational structure, but it is neither cost-effective nor appropriate for information to be assembled and presented by the individual when it can be generated from existing data systems.

Mechanisms should be designed to share governance and feedback information in good time to inform the appraisal discussion.

The GMC states that,

- Organisations must create an environment which delivers effective clinical governance for doctors.
- Clinical governance processes for doctors are managed and monitored with a view to continuous improvement.
- Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination.
- Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practice.

HCS needs to consider how they achieve this, bearing in mind that the relevant regulations apply regardless of organisational scale or capacity, or the contractual relationship that exists between either the doctor or their organisation and the designated body.

Current situation with compliance with GMC Revalidation rules

As part of the co-production with GMC Revalidation of the HCS Appraisal and Revalidation Policy 2022, an agreed suit of supporting metrics (HCS Portfolio of Evidence 2023) was proposed that HCS would collate and provide to all doctors and their appraisers. This has been previously piloted successfully within HCS in 2019 prior to the COVID19 Pandemic.

Unfortunately, since 2019 this information has only been provided ad hoc in appraisals (by individual doctors) due to lack of resource/capability within HCS to collate the required metrics.

The Hugo Mascie-Taylor report and subsequent #BeourBest Assurance Working Group has identified the continued shortfall in capture and collation of these essential metrics to input as supporting information for annual appraisal.

This shortfall in appraisal input data has led to concerns that there is a lack of assurance around local clinical governance processes in sharing information about incidents.

These incidents require reflection and agree changes in practice within the annual appraisal process: e.g., there are recurrent episodes, where a Datix or SI is not shared with a doctor involved in that patients care.

There are also concerns that the quality of data around appraisal inputs is exposing the RO to potential suboptimal information in order to make statutory legal recommendations about an individual doctor's Revalidation to the GMC and exposing patients to unacceptable clinical risk and HCS to poorly defined corporate risks.

Solutions to enhance HCS medical appraisal and give the HCS Board assurance that the RO has the best information to make Revalidation recommendations to the GMC

This proposal sets out solutions which can rectify the current gap in assurance and allow an enhancement of the current Appraisal system with measurable outputs elucidated by continuous quality assurance audit and support from an expanded focused team/ROAG.

To achieve the above objectives, a paper will be submitted to SLT to discuss the resources required and the board will be updated once decisions have been made.

7. Recommendation

It is recommended that the HCS Board support this proposal and the submission of a paper to SLT for discussion.

References

(Medical Practitioners (Registration) (Responsible Officers) (Jersey) Order 2014)

HCS Medical Appraisal and Revalidation policy 2022

HCS Appraisal Inputs Proforma 2023

Academy of Medical Royal Colleges Medical Appraisal Guide 2022

A Framework of Quality Assurance for Responsible Officers and Revalidation DOH/NHS England 2014

NHS England – improving the inputs to medical appraisal 2016.

GMC 2018 - Effective clinical governance for the medical profession

END OF REPORT

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

1. Purpose

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

2. Executive Summary

HCS is dependent on its workforce to deliver high quality and safe patient care. Robust evidence indicates a positive workplace culture enables better patient outcomes, high performing multi-professional teams, improved psychological safety, staff retention and reduced incidents of clinical errors and staff absences. Key strategic drivers including the Review of Clinical Governance Arrangements within HCS (2022) by Professor Hugo Mascie-Taylor, identified the need for HCS to improve its culture and move to become more open, transparent, accountable and striving for continuous improvement. A comprehensive #BeOurBest programme was implemented in August 2022 to address the recommendations of the above report. Through consultation with HCS staff, 145 actions were co-produced and delivered across nine working groups. A review of these actions, in parallel with identified recommendations of serious incident investigations and outcomes of our Be Heard survey 2023 drive the need for a fit for purpose, evidence-based culture change plan within HCS that incorporates performance and people elements of high-quality care cultures and a range of supporting cultural training initiatives and interventions.

3. Applicability to ministerial plan

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

4. Main Report

The Be Heard survey provides information and detail about how an employee feels in the workplace. It focuses on working out what the engagement levels are. When people are engaged, they feel connected to each other and to the aims of the organisation, more motivated and productive. The Be Heard survey for HCS staff was implemented between the 12th June and 30th June on a digital platform. A paper survey has been requested for 350 staff who have expressed a wish to engage in the survey in a non-digital format. The production and implementation of the Be Heard paper survey has been delayed due to the survey being produced with multiple errors.

During July and August 2023, we received HCS whole system Be Heard results and individual care group or service area results. The overall Be Heard survey was completed by 907 HCS staff and represents a response rate of 28.5%. The overall Government of Jersey departmental response rate was 40%. The last Be Heard survey was implemented in July 2020 with an HCS response rate of 43%. The overall Government of Jersey departmental response rate in July 2020 was 56%. Overall, growth was tracked across almost all eight factors of engagement indicating that HCS is moving in a positive direction.

Individual Be Heard results will be disseminated to leadership teams of each care group. Instead of creating action plans for each individual care group, the plan is to focus our attention more intensely on our three top care groups that have been identified for requiring improvements. Maternity services will be one of the key care groups and their individual Be Heard survey results will inform the existing Maternity Improvement Plan and associated actions.

Inpatient and community maternity services within the Women's and Children's (WACs) Care Group is currently engaging in an improvement plan and has been identified as a service area requiring cultural change. An approach using Discover, Design and Deliver is being implemented. The discovery phase involves using a set of diagnostic tools to establish what the culture is within maternity services, where their strengths are and where there needs improvement. To identify the culture of maternity services we have commenced a series of listening events across groups of professionals to understand the staff views of the culture in WACs and across the wider HCS. Emerging cultural themes are identifying the need for improving psychological safety within teams and creating positive supportive environments to enable a shared responsibility for patient outcomes. The Civility Saves Lives programme has been identified as an appropriate evidence-based culture intervention that supports the identified cultural needs. Discussions with the external provider of Civility Saves Lives have taken place and a plan including costings to roll out the programme across HCS and included targeted interventions for identified HCS services areas is currently being developed.

A range of engagement events have been delivered during July including,

- Schwartz Round – 'My Team, Stories of Inclusion'
- Breakfast with Chief Officer
- Team HCS Talks

The HCS wellbeing team have actively been delivering psychological support to self-referred or manager-referred staff. Between January and July 2023, 40 referrals for psychological support have been received.

5. Recommendation

For noting.

END OF REPORT

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Reported incidents of racism within HCS		
Report author (& title):	Dr Cheryl Power (Director of Culture, Engagement and Wellbeing) Washington Gwatidzo (Assistant General Manager, REACH lead)	**Accountable Executive:**	Chris Bown, Chief Officer HCS

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board? *(brief statement & tick as appropriate)* *Any pre-reading*	To provide feedback following the review of 29 reported incidents of racial abuse in Health and Community Services (HCS), to determine if the action taken was appropriate. To feedback the next steps to be taken regarding incidents of racial abuse from service-users (and families) to staff.	Information	√
		Decision	
		Assurance	√
		Update	√

2. Executive Summary

The Government of Jersey's Health and Community Services Department is committed to promoting and improving a safe and secure environment for those who work in or use the service so that the highest standards of care can be made available to patients/service users/clients. The Unacceptable Behaviour Policy, Health and Community Services, December 2022, states it is necessary for management and staff to work together positively to achieve a situation, compatible with the provision of proper services to patients, where a safe and healthy working environment for staff and others can be achieved.

A review of reported incidents of racial abuse within HCS was carried out between the period May 2022 and April 2023. The review involved using Datix, the risk

management information system designed to collect and manage data on adverse events in HCS. The specific search categories of *behaviour/violence/harassment/abuse* were adopted resulting in 29 reported incidents of racial abuse in HCS within the time frame.

All 29 reported incidents had recorded actions. The outcomes for each incident varied from,

- 26 (of 29) incidents recorded on Datix with appropriate immediate actions taken.
- 3 (of 29) incidents recorded on Datix with partial appropriate immediate actions taken.
- 10 (of 29) incidents recorded on Datix with appropriate follow up actions taken.
- 19 (of 29) incidents recorded on Datix with partial appropriate follow up actions taken.

3. Risk and issues

Experiences of racism can negatively affect patient safety, staff health and wellbeing and workforce retention.

4. Applicability to ministerial plan

Understanding the incidents of racial abuse in HCS helps support the development of a healthy and positive working culture in which HCS staff feel they are valued team members working together to meet patient's needs and that they are free to speak up about any concerns they have. The review and proposed next steps will enable a platform for the necessary reform of HCS's internal governance structures that drive learning and continuous improvement and support an engaged and productive workplace environment by listening and engaging with staff.

5. Main Report

5.1 Introduction

The Government of Jersey's Health and Community Services Department is committed to promoting and improving a safe and secure environment for those who work in or use the service so that the highest standards of care can be made available to patients/service users/clients. The Unacceptable Behaviour Policy, Health and Community Services, December 2022, states it is necessary for management and staff to work together positively to achieve a situation, compatible with the provision of proper services to patients, where a safe and health working environment for staff and others can be achieved.

A review of reported incidents of racial abuse within HCS was carried out between the period May 2022 and April 2023. The review involved using Datix, the risk management information system designed to collect and manage data on adverse

events in HCS. The specific Datix search categories of *behaviour/violence/harassment/abuse* were adopted resulting in 29 reported incidents of racial abuse in HCS within the time frame.

During the period of time adopted as part of the review of the incidents, a new HCS policy was ratified in December 2022, The Unacceptable Behaviour policy. The policy includes the approach that HCS will adopt to manage unacceptable behaviour in the workplace. HCS recognises its responsibilities and duties under the Health and Safety at Work (Jersey) Law 1989 and is committed to ensuring, the health, safety and welfare of employees, patients/service users/clients, visitors and other persons who may be affected by its activities. The policy sets out the framework for managing violence and aggression within HCS. The framework has been adopted to review all the 29 reported incidents of racial abuse.

HCS has a duty and responsibility to ensure that staff and volunteers of HCS can go about their work and professional practice without being subject to unacceptable behaviour. The Health and Safety Executive (HSE) definition of work-related violence is,

'*Any incident in which a person is abused, threatened, or assaulted in circumstances related to their work. This can include verbal abuse or threats as well as physical attacks*'.

The National Health Service (NHS) definition of physical assault used for incident reporting purposes is:

'*The intentional application of force to the person or another, without lawful justification, resulting in physical injury or personal discomfort'*.

The NHS definition of non-physical assault used for incident reporting purposes is,

'*The use of inappropriate words or behaviour causing distress and/or constituting harassment*'.

For the purposes of this review and what is defined under the Unacceptable Behaviour Policy, Health and Community Services, December 2022, the following behaviours are stated to be inappropriate,

- offensive or abusive language, verbal abuse and swearing including specific references to homophobia, biphobia, and transphobia (whether aimed at or conducted by either patients / service users / clients or staff)
- any physical violence towards any member of HCS or other patients / service users / clients such as pushing or shoving
- racial abuse
- sexual harassment
- loud and intrusive conversation
- persistent or unrealistic demands that cause stress to staff (requests will be met wherever possible, and explanations given when they cannot)
- unwanted or abusive remarks
- negative, malicious, or stereotypical comments

- invasion of personal space
- brandishing of objects or weapons
- near misses (i.e., unsuccessful physical assaults)
- threats or risk of serious injury to a member of staff, fellow patients / service users / clients or visitors
- bullying, victimisation, or intimidation (including the use of social media)
- stalking
- spitting
- alcohol or drug fuelled abuse
- unreasonable behaviour and non-cooperation such as repeated disregard for HCS policy (i.e., smoking on premises)
- any of the above which is linked to destruction of or damage to property.

Such behaviour can be either in person, by telephone, letter, e-mail, or other form of communication.

5.2 Methodology

The 29 reported incidents of racial abuse were reviewed against the immediate and follow up requirements of what to do if violence and aggression is encountered as stated in the HCS Unacceptable Behaviour Policy, December 2022.

Immediate management of violence and aggression in HCS

- In the first instance a member of the staff should ask the perpetrator to stop behaving in an unacceptable way. Sometimes a calm and quiet approach will be all that is required. Staff should not in any circumstances respond in a like manner. With clients who have an established behaviour support plan, this should be followed.
- If the perpetrator does not stop their behaviour the Line Manager or person in charge should be asked to attend. The member of staff should explain calmly what has taken place, preferably within hearing of the perpetrator.
- If the perpetrator has capacity and is acting in an unlawful manner, causes damage, or strikes another, the police should be called immediately.
- Should it prove necessary to remove the perpetrator from HCS premises, the police should be called. Staff should not, except in the most extreme occasions, attempt to move the perpetrator from the premises.
- If such a course of action proves necessary, those members of staff involved must complete a written note of the incident, detailing in chronological order what has taken place and the exact words used prior to leaving the building at the end of their working day.

Follow up management if violence and aggression in HCS

- Review the incident with the Line Manager or person in charge immediately to determine the severity.
- Decide if a written warning should be given.
- Decide whether to take further action if the matter has been sufficiently dealt with by the advice already given. Such as; the details of any incident other than no further action will be entered into the patient's / service user's / client's record or the employee's personal file; any employee or patient / service user / client or visitor who receives any injury, no matter how small, should be the subject of a Datix Incident Report and should always be strongly advised to be medically examined; every violent incident involving staff will be reasonably supported by the provision of

medical or other treatment as necessary and all incidents should be brought to the attention of the Line Manager or person in charge if not already involved.

- Where the patient / service user / client has capacity, cases of physical assault resulting in an injury upon any member of staff in the course of their duties should be reported to the police.
- In the event of an act of abuse, violence or aggression taking place, it is possible to mark the patient's record to warn other staff of the potential threat of violence. Where an electronic records system is used, a marker can be used to alert staff when they securely access the patient's / service user's /client's record.
- The first concern of managers after an incident is to provide appropriate debriefing and counselling for affected employees. Depending on the severity of the incident this counselling may be undertaken by trained professionals.
- The Manager / Line Manager will assist victims of violence with the completion of the formal record of the incident via Datix and where appropriate will report the incident to the police.
- In the event of serious physical and verbal abuse, a service user may be suspended from using the service for a period.

Each of the 29 reported incidents were categorised as having either,

- appropriate action: adherence to all immediate and follow up management requirements,
- partial appropriate action: partial adherence to the immediate and follow up management requirements.
- no appropriate action taken; no adherence to the immediate and follow up management requirements.

5.3 Results

There were no Datix reported incidents of racial abuse from one staff member to another.

All 29 reported incidents involved a patient/service user and had immediate and follow up actions recorded. The recorded actions for each incident varied from,

- 26 (of 29) incidents recorded on Datix with appropriate immediate actions taken
- 3 (of 29) incidents recorded on Datix with partial appropriate immediate actions taken
- 10 (of 29) incidents recorded on Datix with appropriate follow up actions taken
- 19 (of 29) incidents recorded on Datix with partial appropriate follow up actions taken

Where there were partial appropriate immediate actions identified, these related to 'no harm' being recorded in the Datix system when there was evidence of potential psychological harm following an encounter of verbal racial abuse or when there was evidence that the incident had involved physical restraint. Where there were partial appropriate follow up actions identified, these predominately related to no evidence of a debrief or support offered to staff. There is evidence that staff frequently decline policy guidance to report racial abuse to Police.

Of the 29 reported incidents, 66 % (19) were recorded as happening on adult mental health inpatient wards, 21 % (6) were reported to have happened on a general medical ward, 10 % (3) were reported to have happened in the Emergency Department and 3 % (1) were reported to have happened in a residential setting.

5.4 Conclusion and recommendations

The HCS Senior Leadership Team (SLT) agreed to support an anti-racist statement in June 2023. This approach was supported by the Board during its meeting in July 2023. This will be launched during October 2023.

The review of reported incidents of racial abuse has enabled a more detailed understanding of the occurrence of racial abuse, the quality of reporting racial abuse on the Datix system and whether the immediate and follow up management of incidents are aligned with relevant policies. A number of next steps were identified to be taken regarding incidents of racial abuse from service-users (and families) to staff.

- Revise Datix recording of incidents to ensure incidents provide feedback on immediate and follow up actions of an incident and are aligned with HCS policy.
- Revise Datix recording of incidents to ensure they reflect psychological harm as a harm category.
- Continue with the implementation of the agreed anti-racism statement for HCS through focus group consultation with HCS staff and awareness raising training including awareness of HCS Unacceptable Behaviour policy and all staff and line management required actions following an unacceptable behaviour incident.
- The role of line managers is integral in tackling discrimination in the workplace and in embedding an anti-racism strategy. Role modelling of appropriate behaviour including addressing inappropriate behaviour and promoting inclusion as well as line managers feeling appropriately equipped to manage and support staff when they have experienced an unacceptable behavior incident.
- Continue developing a programme of cross-agency work with States of Jersey Police about the immediate and follow up response to unacceptable behaviour from service users.
- Continue the working group across HCS to specifically reduce incidents violence and aggression.
- Understanding more about the incidence and impact of racial abuse across HCS through use of surveys.
- Routine use of equality impact assessments could help to identify what could be done differently in HCS.

6. Recommendation

Accept the report, note actions taken to-date and support the proposed plan of work.

END OF REPORT

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Progress report against the recommendations of the Review of HCS Clinical Governance Arrangements within Secondary Care		
Report author:	Jo Poynter, Associate Director of Improvement and Innovation	**Accountable Executive:**	Dr Anuschka Muller, Director of Improvement and Innovation

1. Purpose

What is the purpose of this report? What is being asked of the Board?	To provide an update on the progress made against the recommendations from the "Review of HCS Clinical Governance Arrangements within Secondary Care" (2022). Position reported is August 2023. The Board is asked to take note of the progress made and the next action steps outlined against the recommendations.	Information	X
		Decision	
		Assurance	
		Update	X

2. Executive Summary

Details on progress against each of the 61 recommendations of the 'Review of HCS Clinical Governance Arrangements within Secondary Care', by Professor Hugo Mascie-Taylor published in August 2022 are provided in this report.

We are now in the third phase of the programme. This has moved responsibility for the recommendations and actions to operational departments. The action handlers from within the departments are completing the tracker monthly which is coordinated and supported by the Improvement team.

During July and August progress has continued and actions are being led by colleagues across the organisation.

Out of the 61 recommendations, 7 have been marked as complete with a further 11 close to completion. 41 recommendations are in progress; two recommendations have not yet started due to dependencies on other actions.

Key progress has been made with the decision to establish a HCS Advisory Board for 18 months by the States Assembly in June 2023. Recruitment to the non-executive member

roles is progressing well.

During July and August, the triumvirate in each care group has been confirmed and an HCS structure chart showing accountability up to the executive directors has been updated.

With regards to HR recommendations, exit interviews are now offered and a quarterly report is produced by People and Corporate services on the reasons for leaving the organisation.

3. Risks

There is a risk that HCS has not sufficient capacity to manage and address the recommendations as operational clinical and non-clinical resources are extremely stretched due to increasing operational demand and the increasing number of recommendations from clinical reviews and audits that need to be addressed and delivered by the same cohort of people.

4. Dependencies:

The programme of work is dependent on a number of enablers, including:

- Accurate and accessible financial and workforce data is in place to enable accurate workforce and financial management.
- Support for timely and smooth recruitment and on-boarding of new staff. Currently being supported through a Delivery Unit project which started in June 2023.
- Capacity to manage and support the wider improvement programme in HCS.

5. Finance / workforce implications

Continuation of some temporary established resources will need to be considered over the next four months.

6. Applicability to ministerial plan

The development and delivery of an improvement framework is a priority in the 2023 Ministerial Plan.

END OF REPORT

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Mental Health and Capacity Law Report		
Report author (& title):	Andy Weir Director of Mental Health and Adult Social Care	**Accountable Executive:**	Andy Weir Director of Mental Health and Adult Social Care

1. Purpose

What is the purpose of this report? What is being asked of th HCS Advisory Board?	This report provides information and assurance to the Board in relation to the current use of both Mental Health and Capacity Law across HCS, including developmental work being done in this area.	Information	X
		Decision	
		Assurance	X
		Update	

2. Executive Summary

A multi-agency Mental Health and Capacity Legislation Oversight Group was established in 2022 to oversee and develop the use of this legislation across HCS. The group meets monthly and collectively reviews our use of this legislation, identifying any challenges and risks associated with this and developing work plans to address these. Over the last year the group has commissioned training, reviewed and revised procedures, undertaken focused partnership work with the police to successfully reduce use of Article 36 and reduce inappropriate police time on mental health issues, and monitored the use of restrictive practices within the inpatient service.

3. Finance / workforce implications

The regular detailed review of the use of legislation, in particular the identification of any gaps or difficulties, has allowed the Oversight Group to commission training, review procedures and support the workforce to ensure the safe and lawful use of mental health and capacity legislation.

4. Risk and issues

The Oversight Group maintains and regularly reviews a risk register specific to this area.

5. Applicability to ministerial plan

This report supports the intention to advance the quality of services, ensuring they are well governed, safe and patient centred, using information necessary to drive up standards of care.

6. Main Report

a. The Mental Health and Capacity Legislation Oversight Group was established in April 2022, and meets monthly. This is a multi-agency group that includes representatives from mental health and adult social care services, Child and Adolescent Mental Health Services (CAMHS), police, ambulance, the General Hospital, pharmacy and patient advocacy. The Assistant Minister for Health and Social Services with responsibility for mental health attends the meeting on a regular basis. The Oversight Group is coordinated by the Head of Mental Health and Capacity Law, who also has the delegated authority of the Minister for Health and Social Services to manage the day-to-day implementation of the law and ensure strict compliance with all the relevant statutory duties.

b. In accordance with the Terms of Reference for the Group, a core standard agenda exists for each meeting which includes (but is not limited to) the following,

- Report and review of last month's activity (both Mental Health Law and Capacity Legislation)
- Any emerging issues, incidents or concerns and actions require to address these.
- Report on use of Restrictive Practices across the inpatient wards.
- Policy, procedural or proposed legislative changes.
- Training
- Risk Register
- Other business matters

c. Since inception, the Oversight Group has undertaken a range of activities that aim to improve the application of mental health and capacity legislation and the experience of service users who are subject to this. Examples of specific work undertaken by the Group over the last year include;

- A review of various prescribed forms used and development of these.
- Development of patient information leaflets.
- Strengthened procedures for the management of patients detained on long term leave (Article 24) to ensure regular review of detention.
- An audit of the reading of patients' rights for detained patients (this is now ongoing).
- Joint work with the Law Officers Department on the process and use of mental health law for people in contact with the Criminal Justice system (Part 9).
- Development of written standardised transfer procedures for people requiring detention and care off island.
- Implementation of strengthened processes for the authorisation of designated professionals who have statutory roles within the legislation (such as Approved Professionals, Authorised Officers, and Capacity and Liberty Assessors).
- Development of proposals for changes in legislation that are now being progressed through a number of law drafting tranches.

d. Importantly, the Oversight Group provides a regular opportunity for all partners who have a role in the implementation of Mental Health and Capacity Legislation to come together and discuss this in practice. This has resulted in much improved joint working across the system, which is evidenced by some of the changes in use of legislation and practice.

Mental Health Law Assessments

e. During 2023 to-date, there have been 185 Mental Health Law assessments completed - an average of 23 assessments each month. Data in relation to gender, age, ethnicity, sexuality (where recorded) and details of the assessment (time, location, purpose and outcome) are monitored each month.

f. The service has a target of Mental Health Law assessments being undertaken within 4 hours, and monitors this. Of the 185 assessments to date in 2023 (Jan-Aug inclusive), 9 have not met this target and were classified as delayed (5%).

g. Of the 185 assessments to-date in 2023, 105 (57%) have resulted in detention. 17 (9%) have resulted in voluntary admission to hospital, whilst 63 (34%) did not result in admission to hospital at all (but may have resulted in community care and treatment).

h. The vast majority of people assessed under Mental Health Law are aged between 18-65 (148 people - 80%). However, 10 people (5%) were aged under 18, whilst 27 (15%) were aged over 65.

i. Since the beginning of 2022, there have been 2 instances of unlawful detention, as a result of the legal documentation not being correctly or fully completed. Both of these were identified within a short period of time and the patient was held under emergency powers that exist within the law whilst the assessment was refreshed, and the documentation completed. On both occasions the patient was notified of this, in accordance with our duty of candour, and this was followed up in writing.

j. The oversight group has identified a consistent theme in relation to documentation errors which, whilst not resulting in an unlawful detention, can be improved. This is therefore monitored monthly, and discussions are had with the relevant clinicians in order to improve our collective practice in this area.

Article 36 – police holding powers.

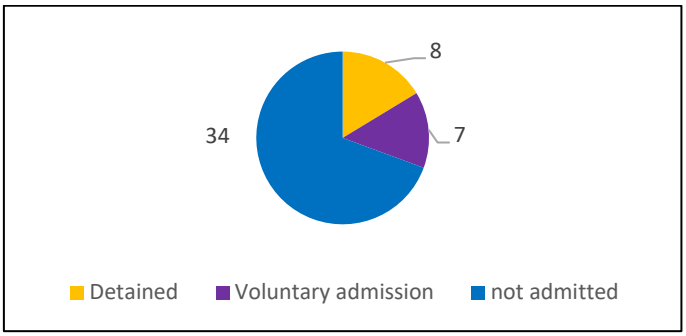
k. Much work has been undertaken in partnership with the police to reduce the use of Article 36 - which provides a police officer with the power to detain for assessment a person who they believe may be suffering from a mental disorder and presenting a potential risk to themselves or others - where an appropriate alternative is available.

l. In 2021 there were 163 uses of Article 36. This was reduced to 112 in 2022, and to date (Jan-Aug inclusive) there has been 49 uses in 2023.

m. 7 of these 49 uses (14%) related to young people aged under 18.

n. The outcomes of the use of Article 36 are shown below. Of the 49 uses to date in 2023, 15

(31%) have resulted in admission to hospital – either voluntarily or as a detention under Mental Health Law.



o. The reduction in the use of Article 36 has been achieved through a collaborative approach with the police, which has included identification of alternatives, introduction of more robust crisis response, training and case discussion. This has also resulted in a reported 32% YTD reduction in the use of police time associated with mental health issues (900-hour reduction).

p. Work is currently underway to finalise the arrangements for the opening of an Article 36 Suite towards the end of this year when the refurbished Clinique Pinel building is occupied. This will result in a reduced use of the Emergency Department as a place of safety and will allow the police – when safe and clinically appropriate – to hand over the care of the detained person to mental health staff within a designated clinical environment; this is clinically more appropriate and will also further reduce the time required from police officers whilst the Mental Health Law assessment is undertaken.

Restrictive Practices

q. The use of restrictive practices within the inpatient service are monitored and discussed on a monthly basis, in order to ensure these are used only when absolutely required. This includes the use of MAYBO (physical interventions to maintain safety), seclusion, individuals subject to planned searches, and restriction of access to electronic media and communications (which may include mobile phone). The data for 2023 is shown below.

	Jan	Feb	March	Apr	May	June	July
Seclusion	1	0	4	0	0	3	2
Use of MAYBO	10	5	9	5	14	8	15
Individuals subject to planned search	0	1	2	1	2	2	0
Restricted electronic media	1	0	0	0	0	0	0

r. Use of physical intervention (MAYBO) frequently relates to the management of potential violence / aggression or prevention of harm to self, or the use of physical restraint to administer medication by injection. However, these figures also include the use of low-level physical holds to manage safety and reduce distress for patients with dementia on Beech

ward.

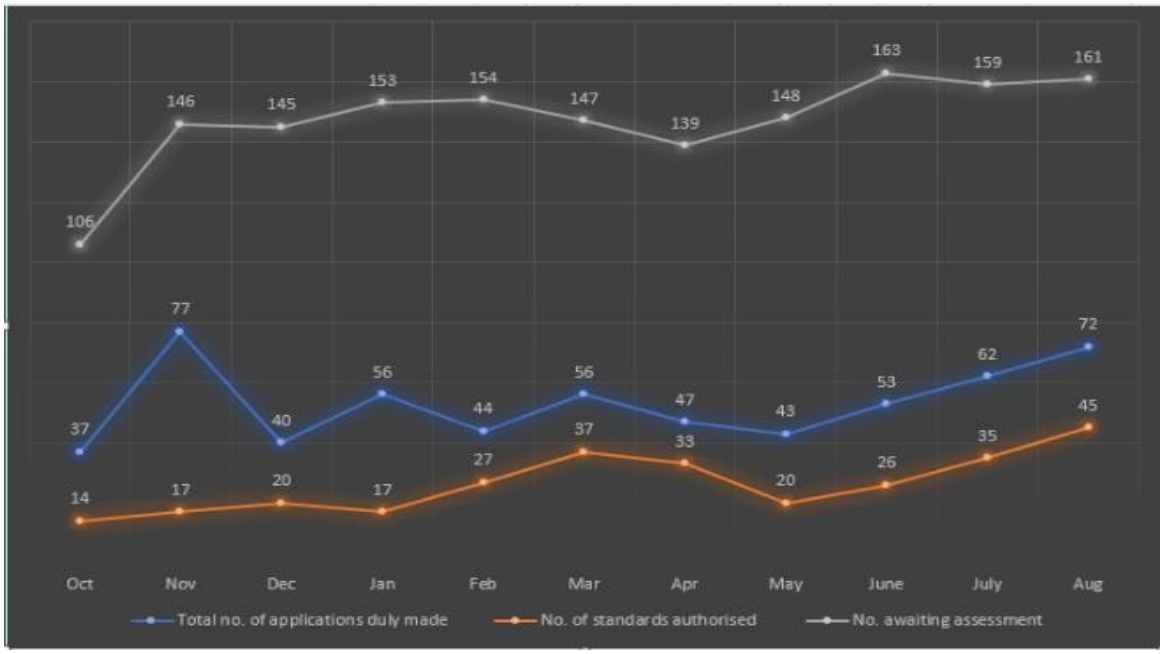
s. A particular challenge for the team in Orchard House has been the limitations of the physical environment of the seclusion room in Orchard House, which has been the subject of significant physical damage in recent months (resulting in periods of not being usable, which creates a significant clinical risk in this setting). Work is underway to ensure that the seclusion and intensive care areas within the refurbished Clinique Pinel building are of a higher standard, in order to maintain safety for all.

t. A revised Rapid Tranquilisation policy has been developed by the Consultant Pharmacist for mental health and approved in August; from September the Oversight Group will incorporate the monitoring of rapid tranquilisation into the restrictive practice data.

Capacity Legislation

u. The Oversight Group also monitors the use of the Capacity and Self Determination (Jersey) Law 2016, and in particular the number of assessments requested and the number of those that result in Significant Restrictions of Liberty (SRoL).

v. As with other jurisdictions, an increase in awareness (supported in Jersey by system-wide training) has resulted in an increased use of capacity legislation. Due to the need for an independent assessment to be undertaken, this has resulted in a backlog as shown below.



w. The Oversight Group has been monitoring this each month and has worked with the HCS Lead for Capacity and Self Determination to implement a number of potential solutions. Unfortunately, due to staff absence and a further increase in applications, this has not yet delivered the required reduction in number of people awaiting assessment (161 in August) despite an increase in the number of standards authorized each month, as shown above. People that are awaiting an assessment are clinically triaged and monitored each month, and we continue to develop plans (including an increase in available trained Capacity and

Liberty Assessors) to address this issue.

Risk

x. The Mental Health and Capacity Legislation Oversight Group maintains a register of risks associated with this work, which is reviewed and discussed every 2 months. Each risk has identified mitigation and assessment of level of risk (likelihood and potential consequences).

y. The current risks associated with Legislation relate to the potential risks of unlawful detention, poor service user experience and reputational risks associated with failure to correctly follow legislation policy and procedures (rated high); risk associated with backlog of SRoL assessments and associated restriction of liberty (in final draft, rated high); and risk associated with lack of understanding of application of capacity law across the health and social care system (rated as a medium risk). Actions are in place to mitigate and monitor each of these risks, via the Oversight Group.

7. Recommendation

The Board is asked to note and discuss this report.

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	October 2023		
Title of paper:	Policy Position Update		
Report author (& title):	Laura Robinson, Policy Manager	**Sponsor (incl. Title):**	Mr Patrick Armstrong, Medical Director

1. Purpose

What is the purpose of this report? What is being asked of Board?	This report is to inform the Board of the current position around policy management within HCS and the proposed changes to enhance the governance processes.	Information	x
		Decision	
		Assurance	
		Update	

2. Executive Summary

Procedural document and policy management remains a challenge; however, significant inroads have been made to improving the position. A quality and safety manager for policy and quality improvement has been recruited to.

A review of the policy position has been undertaken with a clear action plan identified (see appendix 1). There are 535 centrally registered policies, of these 258 are overdue. HCS policy framework has been mapped against a UK hospital to identify some gaps and opportunities. A monitoring and compliance statement has been added to all new policies to enable the policies to be audited against. Compliance and assurance roles to support the monitoring of compliance with policies have been approved and will be recruited to later this year. A policy management system has been approved and will be implemented to provide a single central place for policy development, storage and monitoring.

3. Finance / workforce implications

The licence cost of the recommended policy management system which is due to be implemented by end of Q1 2024 is £17500 p/a (7% annual increase).

4. Risk and issues

- Lack of governance oversight around procedural documentation.
- No single central space to store policies.

- 25 open risks on the risk register which pertain to policies or have policy gaps linked to their mitigation.
- 33 recommendations from four reports identifying policies and procedural recommendations.

5. Applicability to ministerial plan

This paper relates to the Minister for Health and Social Services 2023 Delivery plan, specifically-

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

MHSS P3b.2. Overseeing continued development of services that will: - see the introduction of evidence-based standards of care.

6. Main Report

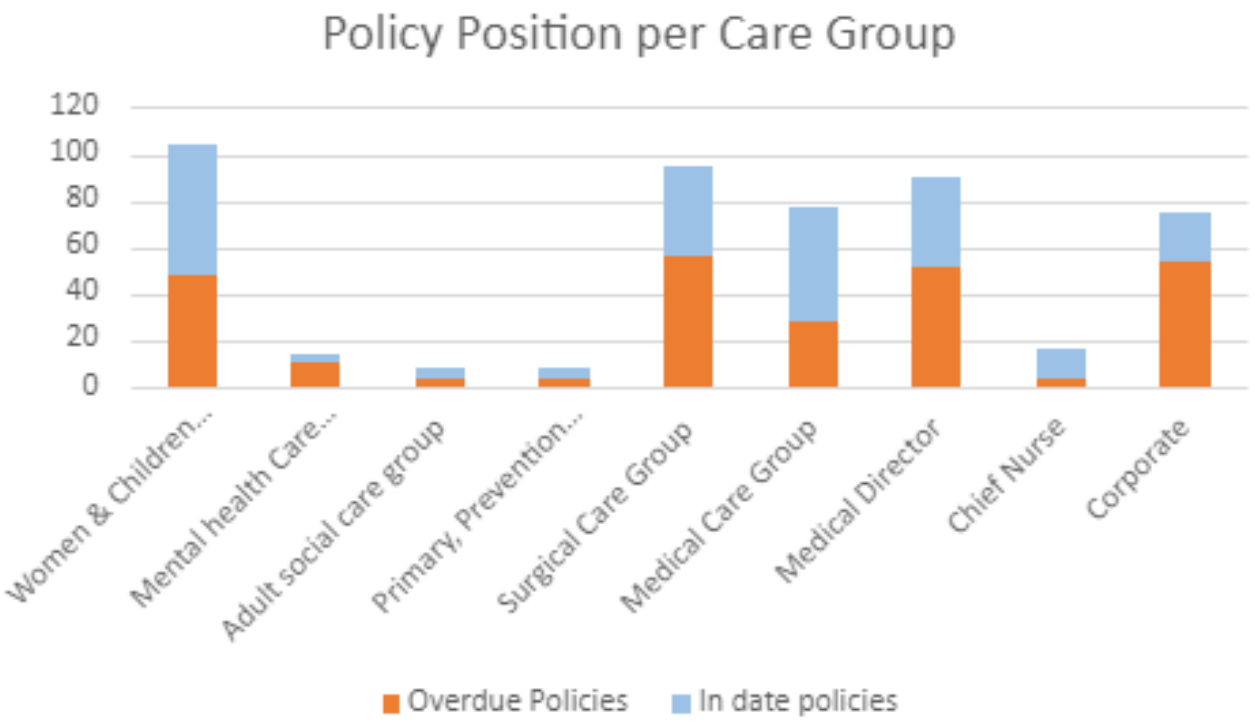
The current position is that there are 535 registered policies, of these 258 are past the scheduled review date. There has been a reduction of 5% in the number of overdue policies and an overall 5% increase in the number of policies of since January 2023.

The Policies and Procedures Ratifying Group (PPRG) is accountable to the Health and Community Services (HCS) Quality and Risk Assurance. Only procedural documents which span more than one care group are ratified and over seen by the PPRG. Procedural documents which are applicable to just a single care group or department should be ratified locally within the care group before being registered on a central register. There is variable adherence with this process across the care groups.

The number of policies that are overdue in each care group will be monitored through the newly formed Care Group Governance Meetings where care groups will be asked to provide assurance on when their policies will be updated.

Care Group	Total policies	Overdue	In date
Women and Children Care Group	104	48	56
Mental health Care Group	14	11	3
Adult social care group	8	4	4
Primary, Prevention and Intermediate Care group	3	2	1
Surgical Care Group	95	56	39
Medical Care Group	77	28	49
Medical Director	90	51	39
Chief Nurse	16	3	13
Corporate	75	54	21

This data is represented in the graph below.



The Quality and Safety Manager for Policy and Quality Improvement has been recruited to. A review of the current policy governance process has been undertaken by the post holder. The review highlighted,

- no single location for storing policies,
- high number of overdue for renewal or review policies,
- policies are not easily accessible and searchable,
- inconsistent adherence to policy ratification process,
- lengthy process for removing and renewing overdue or obsolete policies,
- impossible to assess gaps in policy framework with current system,
- policy approval process is not easy to follow and is open to interpretation across the care groups,
- not all policies are centrally registered once they are ratified at care group level.

There are a high number of overdue policies existing on the system, reasons identified for this are,

- Policy authors move on from roles leaving unclear pathways to pursue renewal.
- Lack of time (job planning for policy work).
- Onerous process for review and renewal.
- Challenging to get engagement on policy development work.

Due to the lack of an appropriately functional system for hosting policies, care group areas have adopted their own systems and processes for storing and managing their policies, further contributing to a lack of oversite, an unclear picture and siloed practises. It is thought there are around 250 local (department level) procedural documents being used which are not registered centrally. These should have been through a care group governance process of ratification, but this is unclear.

There is an inadequate process for the implementation of new policies and no mechanism to monitor the compliance with the implementation or the policy operationally.

An immediate action taken by the Quality and Safety Manager for Policy and Quality Improvement has been to introduce a monitoring and compliance statement to all new policies. This takes the form of an audit schedule created by the policy author outlining the key areas of each policy which should be audited to assure operational compliance. At present we do not audit operational compliance with the policies, but it is expected once the monitoring and compliance statement becomes embedded the policy owners will be responsible for delivering the audit and reporting to PPRG.

An options appraisal has been completed and a new market leading policy management system has been agreed and will be implemented enabling process improvement, access improvements, and oversight improvements. This system is pending implementation scheduling with the Health IT Prioritisation Board and is expected to be in place by the end of Q1 2024. This will provide an effective platform to host all policies, allowing HCS staff to access all registered policies at any time on any device via a secure login. There will be clear oversight from the hospital leadership. The policy system will give visible reporting on who is engaging with procedural documents and will help to clearly identify gaps in policy framework.

Work is ongoing with service areas around the hospital to identify unregistered documents and update overdue ones. Ahead of the new system being implemented a cleanse of all the registered policies will take place. All the obsolete legacy documents will either be removed or updated and not be transferred to the new system, it will be the responsibility of the care group to oversee this. It's not realistic to expect all the overdue documents to be updated ahead of the new system Implementation but it is expected that all the documents will be assigned owners and will be scheduled for update.

By the end of October 2023, a policy will be in place to inform staff that the new policy management system will be in place in 2024 and this will host all HCS policies, care groups will no longer be able to store policies on separate systems and locations. This will ensure that all policies within HCS are part of the policy cycle, registered appropriately and in line with NICE guidance.

The membership and terms of reference of the policy and procedures ratifying group (PPRG) is to be reviewed in December to ensure it is appropriate and is fit for purpose.

Compliance and assurance roles have been approved and are scheduled to be recruited to by the end of Q4. It is expected these roles will support the care groups to manage the program of audits and monitor the compliance with the policies.

The quality and safety manager for policy and quality improvement has,

- set up a shared space for policy development collaboration and for consultation, this has provided improvements in keeping track of the versioning and comments during consultation.

- compared HCS policy framework to a recommended NHS trust.
- improved the process for consultation ensuring there is a consistent consultation schedule in line with the scope of the policy.
- been able to support policy authors through the process of stakeholder engagement and consultation and has been working with departments and care groups to identify and register documents which are in use but are not centrally registered.
- developed the process to support to adoption of NICE guidelines policy.
- has attended the care group governance meetings to provide an updated policy position statement and will continue to do so.

7. Recommendation

Support from the Board to raise awareness of the need to improve governance in the form of procedural document information management.

Support the implementation of the agreed Policy management system.

END OF REPORT

Appendix

Policy Recovery plan

HCS
Laura Robinson

Project Start: 01 May 2023
Display Week: 1

TASK	ASSIGNED TO	PROGRESS	START	END
Policy updates				
Review and upda	Name	90%	1/5/23	4/5/23
Review and update template		90%	4/5/23	6/5/23
unregistered documents		50%	6/5/23	3/9/23
Prioratise over due documents		25%	3/9/23	10/5/24
prioratise and allocate over due documents		15%		
Review PPRG membership			5/5/23	7/5/23
Unregistered documents				
Engage with care groups and depertments to ider		50%	6/5/23	10/5/23
update all unidentified docs		50%	8/5/23	13/5/23
register unidentified docs			13/5/23	16/5/23
Task 4			13/5/23	15/5/23
Task 5			13/5/23	16/5/23
New System				
review process for ratifying policies inline with new system			16/5/23	21/5/23
coms plan			22/5/23	26/5/23
implamentation plan			27/5/23	1/6/23
No System				
agree a location approach			date	date
identify and refine specification and priorities			date	date
determin functionality and reporting			date	date
			date	date
			date	date

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	HCS Management of Overdue Risks		
Report author (& title):	James Moulson - HCS Risk Manager	**Sponsor (incl. Title):**	Mr Patrick Armstrong, Group Medical Director

1. Purpose

What is the purpose of this report? What is being asked of the Board?	To provide assurance that the HCS risk process is being followed and risk position is as accurate.	Information	
		Decision	
		Assurance	✓
		Update	

2. Executive Summary

The HCS Advisory Board can be assured that the overdue risk Key Performance Indicator (KPI) data continues to have an improving trend for 2023.

The detail of this is reported to the Risk Management Committee (RMC) each month (last met on 13 Sept) along with key individual risks that have changed, plus any new / closed risks for oversight.

In March 2023, HCS ceased using an external resource to run the overdue risk notification process which had an immediate negative impact on the April overdue risk position. This was quickly rectified using process automation and work to target problem areas.

To improve risk reporting further, HCS has implemented a new 'risk type' to allow differentiation between HCS Operational, HCS Strategic and HCS Principal risks. Risks at the top level of this hierarchy have a much better (Green) overdue risk position compared to lower scoring operational risks.

3. Finance / workforce implications

Work to automate the overdue risk notifications saves both time and money by removing a dependency on an external consultant to perform the weekly overdue risk reminder process.

4. Risk and issues

Increasing demands on time can prevent timely risk review. To mitigate this, the new risk type reporting will allow prioritisation of HCS most important risks. Also, further data analytic / presentation solutions will be explored to support risk reviews, reporting and

prioritisation.

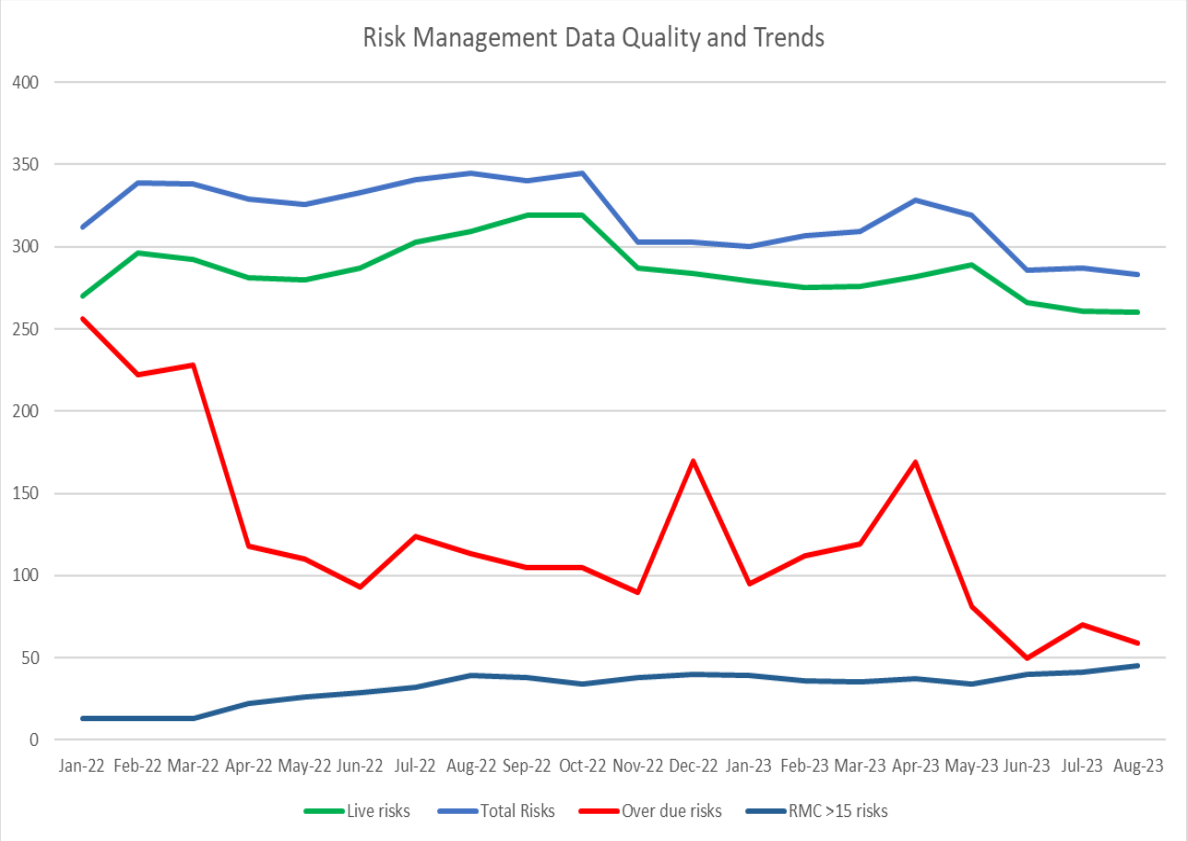
5. Applicability to ministerial plan

HCS Risk Management underpins and enables safe delivery of ministerial objectives.

6. Main Report

The August 2023 risk summit, which replaced RMC, improved July's overdue risk position - the forecast was for this to deteriorate due to staff leave. Completion of the risk summit is planned in September.

The total number of overdue risks continues the downward trajectory for the year and is significantly lower than this time last year (near half) at 70 out of 283.



Overdue risk and assurance KPI data by risk type:

Type	Total Risks This period (previous period)	Total Red >15 This period (previous period)	Overdue Red >15 this period This period (previous period)
HCS Corporate	41 (33)	14 (13)	1 (0)
HCS Operational	243 (250)	31 (28)	4 (0)

** Target introduced 09 March 2023 to check for risks scoring >15 containing Assurance data. This metric looks at all risks classified as HCS Corporate risks. For Operational risks, the target relates to **red risks >15** only.*

7. Recommendation

For the Board to note.

END OF REPORT

Report to:	Health and Community Services Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	HCS Mandatory and Statutory Training		
Report authors (& title):	Tim Hill Practice Development Sister Jessie Marshall Chief Nurse Andy Weir Director of Mental Health and Adult Social Care	**Accountable Executive:**	Jessie Marshall Chief Nurse

1. Purpose

What is the purpose of this report?	This paper provides a proposal to implement an agreed Mandatory and Statutory Training for all staff employed across HCS.	Information	
		Decision	X
		Assurance	
What is being asked of the HCS Advisory Board?	The Advisory Board are asked to discuss and agree the proposal.	Update	

2. Executive Summary

It is a fundamental requirement of HCS (linked to Health and Safety, Jersey Care Commission (JCC) and professional standards) that we are able to demonstrate that staff are provided with the appropriate core training to safely deliver all aspects of safe and effective care. Currently there is no agreed mandatory and statutory training programme in place for HCS, beyond the central Government requirements for all employees. Work has been undertaken to agree a Mandatory and Statutory Training Policy, which has been approved in principle. However, it is now necessary to agree the detail of the training that will be determined as mandatory within HCS in order to implement the policy. This paper sets out a proposal for this, separating mandatory training requirements into two core groups – all staff, and staff who are clinically / service user facing. Further role specific training will be specified for each care group / service area as part of the next phase of this work.

3. Finance / workforce implications

This proposal will require all staff to complete the designated mandatory training at the agreed

frequency. Much of this training is already being completed by staff, but full compliance will result in a potential staffing impact (release of staff) in some areas that will need to be effectively managed.

A wider implication for HCS is the need to record and monitor compliance with designated mandatory training; this has a minor resource implication that will be managed through the Senior Leadership Team.

There are also some implications around ensuring adequate capacity to deliver the required level of mandatory training; this again will be determined in more detail as part of the implementation plan and addressed through the Senior Leadership Team.

4. Risk and issues

The key potential risk relates to the need to ensure compliance with designated mandatory training across all areas; this is a well-rehearsed concern in many similar (NHS) organisations that often attracts attention from the regulator (CQC). It is essential that HCS are able to implement / deliver and monitor uptake of training that is identified as mandatory.

5. Applicability to ministerial plan

The Ministerial Plan for Health and Social Services aims to advance the quality of Government of Jersey health and care services, ensuring they are well governed, safe and person centred. The implementation of a programme of mandatory and statutory training for all staff supports this intent.

6. Main Report

a. As identified above, although a wide range of training – including some statutory training – is currently delivered across HCS, there is no formally agreed matrix of mandatory training for staff. The Senior Leadership Team (SLT) have committed to developing a defined schedule of mandatory training for all staff, which will then be monitored in terms of compliance.

b. The SLT have proposed and supported an initial target level of compliance of 85%

c. Currently, all new Government of Jersey employees are required to undertake a series of corporate on-line eLearning training programmes, and to update these on a prescribed basis. This includes programmes relating to Cyber Security, Data Protection, Dignity and Respect, Diversity and Inclusion, Health and Safety, Children's Rights and customer experience. This collectively equates to 3.75 hours of online training.

d. In addition to this, it is necessary to undertake some specific HCS training at induction, much of which then feeds into a rolling programme of mandatory training. This is currently delivered in part through the local HCS induction programme.

e. Significant work has been undertaken (led by Practice Development Sister) to identify

the core training that should be identified as mandatory for all staff, and for all staff that are directly patient / service user facing, and the frequency that this is required. Where there is a statutory / legal requirement, this is reflected in the schedule.

f. Beyond this, there is other specific training that will be required for all staff within discrete areas – for example, Paediatric Life Support training for all paediatric staff, or detailed mental health legislation update training for staff in mental health services. It is proposed that the detail of this training is agreed for each service area as the next stage of implementation.

g. The proposed mandatory training matrix is therefore attached as Appendix 1.

Induction

h. On induction, all staff will be required to undertake 13.5 hours of face-to-face training and an additional 3.5 hours of eLearning. If organised well, this face-to-face training could be delivered over 2 days.

i. For clinical / service user facing staff, excluding the MAYBO training an additional 8 hours of face-to-face training is required. Again, if organised well this means all face-to-face training for these staff could be delivered in a scheduled 3-day block.

Ongoing mandatory training

j. Thereafter, the face-to-face mandatory training requirement for all staff is 6.5 hours every 2 years and an additional 4 hours every 3 years, with an additional eLearning requirement of 1 hour annually, an additional 1 hour every 2 years and an additional 1.5 hours every 3 years.

k. Clinical / service user facing staff will have an additional 5 hours face to face requirement per year (which can be delivered as a single clinical update day on a regular basis) and an additional 4 hours every 3 years.

l. Information Governance mandatory training is delivered as part of the corporate GoJ training programme for all staff and is refreshed annually. In addition to this, we currently plan to develop an HCS specific refresher for all clinical staff.

m. In addition to the training described in the matrix, there are two current initiatives that are being explored / developed which may be included in mandatory training for clinical staff moving forward – these relate to suicide awareness and the Oliver McGowan training on learning disability and autism.

n. The organisation and monitoring of mandatory training will require some initial resource. Currently there is not an electronic platform available that will capture and report on mandatory training, although it is anticipated that this may become available with the roll-out of the next version of the Connect Learning system. This is currently being explored by the Associate Director of People for HCS.

o. Therefore, we are proposing a fixed term post is created to support the organisation, delivery and reporting of mandatory training, and this will be progressed through the Senior Leadership Team.

p. As indicated above, in parallel with the implementation of this mandatory training matrix, further work will be undertaken to identify the specific training that is locally required for all staff groups in each of the service areas / care groups, and this will then be built into a local training matrix and appended to the Mandatory and Statutory Training policy.

7. Recommendation

The Board is asked to discuss this proposal and endorse the implementation of the proposed mandatory training framework.

Mandatory Training Schedule: All Staff

Training	Induction	Delivery mode	Length	Mandatory Update
Health and Safety	√	Face to face	4 hours	3 yearly
Safeguarding Level 1	√	Face to face and workbook	2 hours	-
Safe Handling	√	Face to face and eLearning	3.5 hours	2 years (reduced to 1.5 hours)
Fire training (includes extinguisher and evacuation)	√	Face to face	3 hours	2 yearly
Infection Prevention and Control	√	Face to face	1 hour	2 yearly
Lone working	√	eLearning	0.5 hours	3 yearly
Mental Health Awareness	√	eLearning	0.5 hours	3 yearly
MAYBO Positive Approaches	√	eLearning	1 hour	2 years
Fire safety awareness	√	eLearning	1 hour	Annually
Health and Safety Risk Assessment	√	eLearning	0.5 hours	3 yearly

** Local health and safety and fire safety inductions are also required on commencement of employment, to be delivered locally*

Mandatory Training Schedule: All Clinical / Service User facing staff (in addition to above)

Training	Induction	Delivery mode	Length	Mandatory Update
Adult Basic Life Support	√	Face to Face	2 hours	Annually
Infection Prevention and Control Clinical Refresher	-	Face to Face	1 hour	Annually
Safe handling update	-	Face to Face	1 hour	Annually
Mental Health and Capacity Law update	-	Face to face	1 hour	Annually
MAYBO level 2 - assault avoidance and disengagement	√	Face to Face (based on local TNA)	**To be confirmed**	2 yearly
Safeguarding Level 2 *	√	Face to Face	4 hours	3 yearly
Capacity and Mental Health Law	√	Face to face	2 hours	-
Information Governance	√	ELearning	1 hour	2 yearly
Fit Mask Testing	√	Face to face	1 hour	2 years

** Clinical staff are also expected to undertake an additional 2 hours safeguarding training every 3 years relevant to their role*

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Appointment of Consultants		
Report author (& title):	Steve Graham	**Accountable Executive:**	Chris Bown

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board?	To describe to the Board the process by which appointments to senior clinical and non-clinical roles are made and provide assurance on the process.	Information	x
		Decision	
		Assurance	x
		Update	

2. Executive Summary

This paper describes how the current approval process followed by Health and Community Services to recruit to both clinical and non-clinical roles will be adapted now the Board is in place.

Medical Consultant and Senior non-clinical roles will be approved by the Board prior to seeking approval from the States Employment Board (SEB).

3. Finance / workforce implications

Ensuring the right approval process is in place to recruit substantive employees and reduce agency and agency spend.

4. Risk and issues

Nil identified.

5. Applicability to ministerial plan

The recruitment to substantive roles and reduction of the use of agency is part of the ministerial plan.

6. Main Report

Introduction

Health and Community Services (HCS) has in place several governance and approval processes that are undertaken before recruitment to a role begins.

Most of the recruitment approval for roles within HCS is obtained via the Workforce Expenditure Approval Request (WEAR) form, which is initiated by the recruiting manager and approved by the department finance support to confirm there is funding available before being signed off by the Chief Officer or delegate. This process will not change with the introduction of the Advisory Board.

However, in 2011 a proposition was passed in the States Assembly (Proposition P.59/2011) which introduced the requirement for the approval of the States Employment Board (SEB) before recruitment and appointment to any role across Government which was either.

Civil Service Grade 15 or equivalent

or

On a salary of £100,000 or over

or

A Contractor on a day rate in excess of £380

or

A Medical Locum role

Within HCS, the salary criteria result in the need for the approval of SEB for the recruitment of every medical consultant role, even if that role is a replacement for an existing role and is in the structure.

The form that is submitted is completed by the relevant clinical lead and is signed by the Chief Officer of HCS, the Minister for Health and Social Services and the Chief People Officer of the Government before it is submitted to SEB.

With the introduction of the Advisory Board, it is now proposed that the request to recruit to medical consultant roles will be approved in the following order:

1) By the leadership team of the appropriate Care Group
2) By the Senior Leadership Team of HCS
3) By the Advisory Board
4) By SEB

7. Recommendation

The Board is asked to note the proposal for the approval of request to recruit to medical consultant roles will be approved through the Advisory Board prior to seeking SEB approval.

END OF REPORT

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	4th October 2023		
Title of paper:	Health and Community Services Estates Report		
Report author (& title):	Jon Carter – HCS Head of Estates Andrew Ross - EY	**Accountable Executive:**	Claire Thompson, Director of Clinical Services

1. Purpose

What is the purpose of this report? What is being asked of th HCS Advisory Board?	To provide an overview report to HCS Advisory Board on the buildings and physical estate that compromises HCS and introduction to the roles and structure of the Health and Community Services Estates team.	Information	Y
		Decision	N
		Assurance	Y
		Update	Y

1.1 Existing hospital estate overview

The following sections set out the current arrangements for delivering healthcare services in Jersey and why the existing arrangements are preventing us delivering the objectives. This section will focus on the:

- The history and physical condition of the healthcare facilities
- Poor functional suitability and configuration of the healthcare facilities
- Poor resilience of the healthcare facilities
- Roll of the Estates team

2.0 History of the site

Jersey General Hospital is a significant 40,032m² facility located in the heart of St Helier and operates as the only acute and general hospital facility on the island. It is located on a heavily developed town centre site of some 1.85 hectares with blocks extending up to eight storeys high.

Most of the current clinical facilities date from the 1960s, but with the granite block dating back to 1765, and as a result exhibits serious levels of dilapidation. Significant elements of building structure and engineering services are now beyond their useful economic life and will need to be replaced soon.

In response to concerns over the extent of dilapidation and functional obsolescence, and to ensure that it adopted a responsible approach to premises management, HCS commissioned a specialist report in 2015 that considered the extent of deficiency against current UK NHS premises standards. It considered the use, condition, and compliance of the facilities against the following six key aspects.

Table 1: Six Facet Survey

Survey Facet	Approach
Facet 1 – Physical Condition	Reviewing building fabric and engineering services;
Facet 2 - Statutory Compliance Audit	Reviewing Fire, health and safety and other legislation;
Facet 3 - Space Utilisation Audit	Examining the intensity of use of the hospital's spaces and functional areas;
Facet 4 - Functional Suitability Review	Reviewing the internal space relationships, availability and appropriateness of support facilities and their location.
Facet 5 - Quality Audit	Considering spatial amenity, comfort and design appropriateness and quality;
Facet 6 - Environmental Management review	Considering the overall efficiency of the property, with energy being a critical factor.

An update to this review was undertaken for a second time in 2019 and the findings of this updated six-facet survey are set out below. The survey confirmed the following:

Except for some refurbished areas, the majority of the hospital's external fabric and engineering services have exceeded design life and are considered to meet classification category C, which is below satisfactory standard and needing major replacements within one year for engineering elements.

- Although major refurbishment of some areas, such as operating theatres have been undertaken in the last ten years, the building footprint is still significantly below the size and configuration that meet the functional requirements of modern operating theatre standards.
- Some aspects of statutory deficiency are difficult to address due the physical construction of the buildings or where only reconstruction would address the issues.
- Many areas of the hospital exhibit poor functional suitability and are classified as below that which would be considered as unacceptable against UK NHS standards (D).
- Due to their age, many of the operational spaces do not meet current Health Building Notes (HBN) standards, restricting both the effectiveness and safety and

have poor positional relationships with other functions within the hospital.

- Some building areas are of poor quality in terms of their effectiveness as working environments and as spaces for modern healthcare.
- Spaces are cramped and would not achieve common healthcare standards such as the HBN standards used in the UK.
- There is a general absence of rooms dedicated to confidential conversations with staff, patients, and carers and between staff members.
- Cramped and inflexible office areas exist on most floors.

A summary of the key is set out below.

Key:

A: building complies with all statutory requirements and relevant guidance.

B/F building where action will be required in the current plan period to comply with relevant guidance and statutory requirements.

C: building with known contravention of one or more standards which falls short of B.

D: building areas which are below C standard.

X: Supplementary rating added to C or D to indicate that nothing, but a total rebuild, or relocation will suffice (that is improvements are either impractical or too expensive to be tenable).

Figure 1: Extract from the 2019 Six Facet Survey

Building block	Year of build	Physical Condition	Functional Suitability	Space	Quality	Fire, Health & Safety Requirements		Energy
						Overall Fire Assessment	Overall Health & Safety Assessment	
Blk A Parade Building	1987	C	D/X	F	D	C	C	C
Blk B 1960 Wing Building	1960	C	C	O	C	C	C	C
Blk C Granite Building & Gatehouse	1860	C	D	O	C	C	C	C
Blk C Gatehouse	1877	B/C	*N/A*	*N/A*	*N/A*	*N/A*	B	D
Blk D Peter Crill House Building	1950	C	B	B	C	B	C	C
Blk E Gwyneth Huelin Wing Building	1979	C	C	C	C	C	C	C
Blk F Pathology/ Pharmacy/ Kitchen	1983	C	D	O	D	C	C	D
Blk G Engineering Building	1980	C	C	O	D	C	B	D

The poor condition of the existing hospital highlighted in both iterations of the six-facet survey is also of broader concern as:

- Its condition and configuration are not in keeping with modern healthcare and is unlikely to be consistent with the contemporary expectations of the island's population.
- As a strategic asset, the hospital's poor condition and potentially more limited capability due to spatial constraints is likely to form a disincentive or barrier to the islands efforts to recruit key individuals to work and live on the island.
- Adopting a 'watch and wait' estates strategy can only be a very time limited approach as the likelihood of a building failure or statutory breech will only increase.

3.0 The current condition of the hospital estate

As has been set out, the General Hospital site comprises of a number of buildings across a large site, with clinical accommodation dating generally from the 1960's but with the Granite Block C dating back to 1765. There is a disparate collection of buildings developed over a long time to different health policies, operational practices, and construction standards. As a result, facilities are in poor condition with the worst areas of building and engineering infrastructure presenting daily operational difficulty.

As a result of the Six Facet Survey, it is now known that some aspects of the hospital are in a sufficiently poor condition that the risk of building failure is high and is increasing each year. In these cases, the scale of such a failure would severely limit the hospital's ability to manage its way through any emerging crisis resulting in a significant risk of building closure and health service interruption.

A detailed 'six-facet' survey undertaken by specialist consultants in 2015, confirmed that, despite significant capital investment, see Financial Table below, the decline had continued now to a point where full refurbishment or complete infrastructure replacement would now be required.

Table 2: 2019 six-facet financial summary – hospital

			2019	2020	2021	2022	2023	2024	2025	2026
			Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
		Blk A	£5,907,161.35	£107,784.95	£61,728.63	£184,701.55	£249,317.36	£62,636.45	£557,864.92	£2,795,233.04
		Blk B	£2,083,239.58	£41,109.77	£0.00	£5,410.94	£68,991.47	£0.00	£144,130.41	£163,796.51
		Blk C GH	£40,348.63	£701.67	£228.37	£228.37	£1,245.23	£3,040.44	£2,172.00	£228.37
		Blk C	£2,329,118.07	£906,394.29	£80,275.98	£2,187.40	£331,029.40	£14,833.30	£324,233.83	£205,077.18
		Blk D	£1,539,708.43	£187,063.07	£76,112.21	£128,927.95	£1,095,327.22	£6,934.79	£128,820.66	£192,802.42
		Blk E	£6,218,435.67	£217,256.61	£480,041.82	£110,490.92	£397,301.99	£0.00	£351,255.47	£113,465.87
		Blk F	£3,523,601.38	£147,190.63	£28,520.00	£72,247.31	£933,604.86	£35,650.00	£32,024.14	£82,996.86
		Blk G	£1,505,769.85	£283,524.92	£6,894.74	£7,157.49	£246,074.74	£11,507.81	£58,387.82	£38,623.77
Works cost	**£54,871,514.40**	**Total**	**£23,147,382.96**	**£1,891,025.90**	**£733,801.75**	**£511,351.93**	**£3,322,892.28**	**£134,602.79**	**£1,598,889.25**	**£3,592,224.02**
Additional costs	£283,310.00		£283,310.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
(inc. Jersey %)										
SUB TOTAL	**£55,154,824.40**		£23,430,692.96	£1,891,025.90	£733,801.75	£511,351.93	£3,322,892.28	£134,602.79	£1,598,889.25	£3,592,224.02
PRELIMINARIES (20%)	**£11,030,964.12**		£4,686,138.40	£378,205.00	£146,760.20	£102,270.20	£664,578.46	£26,920.56	£319,777.80	£718,444.80
CONTINGENCY/RISK (12%)	**£6,618,578.48**		£2,811,683.04	£226,923.00	£88,056.12	£61,362.12	£398,747.07	£16,152.33	£191,866.68	£431,066.88
PROFESSIONAL FEES (14.52%)	**£8,006,085.00**		£3,402,136.48	£274,576.83	£106,547.91	£74,248.17	£482,483.96	£19,544.33	£232,158.68	£521,590.92
OVERALL COST	**£80,810,452.00**		**£34,330,650.88**	**£2,770,730.73**	**£1,075,165.98**	**£749,232.42**	**£4,868,701.77**	**£197,220.00**	**£2,342,692.41**	**£5,263,326.62**

Cumlative Costs	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
	£34,330,651	£37,101,382	£38,176,548	£38,925,780	£43,794,482	£43,991,702	£46,334,394	£51,597,721

Capital Backlog Maintenance Fund	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
	£2,850,000.00	£5,000,000.00	£5,000,000.00	£5,000,000.00	£5,000,000.00	£5,000,000.00	£5,000,000.00	£2,595,000.00

Deficit In Funding Gap (-)	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
	£31,480,650.88	£32,101,381.61	£33,176,547.59	£33,925,780.00	£38,794,481.77	£38,991,701.78	£41,334,394.19	£49,002,720.81

Faced with this, the hospital's estates team identified the major areas of concern and implemented a tactical backlog investment plan to address the most serious and technically correctable issues. However, this recognised and relied upon the intention to develop a new hospital and therefore targeted investment to key areas of the poorest condition or of imminent failure only whilst implementing increased monitoring of the hospital's overall condition. Consequently, significant dilapidation remains.

An updated review was carried out in 2019 which highlights further rapid deterioration of the overall condition of the Hospital. Reconfiguration of the current building will, in nearly all aspects, require investment to address infrastructure issues whilst at the same time not addressing the inherent space, clinical flow and adjacency issues.

Complete redesign of the hospital is required to meet the current and future acute clinical needs of the population and detailed clinical reconfiguration will form an integral part of the future development of a new hospital.

The table below summarises some aspects emerging from the 2019 six-facet report and confirms the extent of corrective work needed and which could not be delivered in an active General Hospital with little redundancy.

Table 3: 2019 six-facet survey summary

Estate Element	Condition
Fire Code Compliance	There is currently limited means of horizontal evacuation for patients possible above the 3rd Floor level of the Parade Block. Investment in sprinkler systems, fire escape lifts and improved fire safety compartmentalisation would severely reduce the functionality of this block given that it was not initially designed to accommodate them. Correcting fire safety would therefore result in a net space reduction. Additional fire compartmentation works have been commissioned in ward locations that do not impair on the space or ward activity.
Fire Alarm Systems	The Fire Alarm and Detection System was obsolete and failing. A critical system, this was replaced during 2016/17. Requiring full engagement of designers, users, contractors, and Estates over a two-year period, with fire detection coverage being maintained throughout, requiring excessive management resources and communication at all times.
Water System Compliance	The aged design of the current hot and cold-water systems provides a risk of contamination from Legionella and Pseudomonas aeruginosa. Insufficient water flow through pipework due to change of use/models of care within wards/departments, and temperature-controlled water faucets mean that Legionella avoidance will become increasingly challenging. Intensive management controls and continuous investment in remedial works and ongoing system disinfection is completed to reduce risk. However, evidence in other hospitals indicates that system replacement is a high priority but again, could not be achieved without significant disruption to the operational hospital.
Electrical systems and emergency power	Significant elements of the hospital's electrical distribution system are dilapidated and would not meet common hospital standards such as the UK HBN standards. Emergency generators date from the 1960's and switchgear, transformers and electrical infrastructure installed in the 1970's are well beyond their 30-year life expectancy. New generators have been installed within the existing grounds of the General Hospital and connected to the existing electrical infrastructure as mitigation to service failure.

Medical Gas Supply	The medical gases infrastructure, plant and manifold rooms would not all meet current UK Health Technical (HTM 02-01) Standards. The provision of medical gases to some departments is also below current minimum standards with the Maternity Unit having no piped Entonox until it was added during the current refurbishment in early 2023, Renal Unit having no piped oxygen or vacuum. Site wide infrastructure is weak, missing elements of plant and pipework needed to meet the level of supply security expected in a modern hospital. The use of cylinder-based supplies is therefore high but poor site configuration, and the lack of facilities results in inappropriate storage and poor manual handling practices. The existing piped system requires modernisation to comply with current standards such as the UK HBN standards. The existing configuration poses an increased risk to safety shut off and compliance. This is currently being reviewed as part of the safety backlog work. Mitigation has been carried out on elements of the existing MTHW system to reduce risk, but ongoing works are still required, on a reactive basis, to manage the system until the new facility is ready.
Mains Drainage	The current foul drainage systems vary in age, material, and design. In many cases they were not designed to meet their current loading and, combined with their poor internal condition, are leading to increased blockages and overflow within the hospital. Previous Incidents have required partial ward/department shutdowns, requiring deep cleaning and decontamination to IP&C standards and/or the contaminated equipment/furnishings and flooring replacement. Existing concealed drainage runs are inaccessible which limits survey, repair, and replacement. This has an impact on developing equipment i.e.: macerators cannot be installed.
Air Handling and Ventilation	Specialist healthcare air handling and extract units providing 24-hour conditioned air for the hospital are corroded failing mechanically, and obsolete. Failure of systems that filter air to Ultra clean standards or provide positive pressures will result in ward and department closure.
Energy Centre	The current Energy Centre requires major works to replace existing boilers, chimney, primary heating system, ancillary plant items, Building Management System, and pipework hangers. As the primary heating and hot water source for the hospital this centre presents a significant single point failure risk if not mitigated.
Asbestos	There is significant asbestos within the current hospital following its historical use to thermally insulate steam, and other hot water pipework. Its presence makes building maintenance and refurbishment extremely difficult with its specialist removal having to be managed during any building change. Asbestos management plans are in place to ensure the safety of staff, the public and contractors.

4.0 Mental health facilities

Orchard House, Clinique Pinel and Rosewood House - St Saviours currently delivers Mental Health Services, including inpatients admissions. The geographical isolation of Orchard House and the current condition of the environment, both internal and external,

require the service to be co-located into the Clinique Pinel Building.

Orchard house underwent essential maintenance works in 2019 at a cost of £670k to comply with a Health and Safety Inspectorate (HSI) notice. However, despite this investment, Orchard House is expected to close within the next Q3 2023 with Mental Health Services transferring into Clinique Pinel and Rosewood House. To accommodate the transfer of these services, Clinique Pinel is currently undergoing a £7.9m refurbishment / extension. The project is currently due to complete in September and the facility being fully occupied by December.

The challenges facing Mental Health Services are well known and some elements are consistent with most health and care jurisdictions. Key issues include the following:

- Physical and mental health services are not currently integrated.
- There is a recruitment challenge for key skilled roles such as Registered Mental Health Nurses, Medical Staff and Allied Health Professionals.
- The current Mental Health Estate does not provide a therapeutic environment of care.
- There is a lack of care co-ordination.
- The wider system of Government such as Housing and Economic prosperity need to be linked to our strategic plans for mental health.

The need for the relocation of the service provided is primarily driven due to the clinical, operational, and environmental risks. The upgrade of the current Orchard environment was considered but ruled out due to a number of the identified risks not being mitigated through this approach.

As a result, facilities are in poor condition with the worst areas of building and engineering infrastructure presenting daily operational difficulty. Complete redesign of the mental health facilities is required to meet the current and future mental health needs of the population.

5.0 Other healthcare facilities in Jersey

In addition to the Jersey General Hospital and the St Saviours sites, there are four key additional sites which deliver healthcare services. These sites are:

- Overdale Hospital site
- Enid Quenault Health find Wellbeing Center
- Five Oaks
- St Peter Cratering Unit

Overdale provides a range of healthcare services including rehabilitation, a children's development and therapy centre, older people mental health and memory services and specialist outpatient facilities and clinical and non-clinical support services.

Following on from the commitments for the Our Hospital Programme, Enid Quenault, former Les Quennevais School has been converted into a bespoke outpatient's facility to re-provide most of services provided at Overdale. This move supports the now New

Hospital Facilities Programme in clearing the site for redevelopment. Currently only Samaras Ward, our inpatient rehab unit remains at Overdale.

Five Oaks currently provides the Theatre Sterile Supply Unit, Hospital Laundry, and Central Stores.

St Peter Catering Jersey General Hospital's catering facilities are currently delivered off-site at the St Peters Industrial Park. This site is rented at a cost of £313k per annum over a 20-year lease (circa £6.2m).

The entire Health Estate (100+ properties) is a mishmash of other non-clinical facilities which include accommodation, office facilities, storage, and day centres. A full list of properties can be found in Appendix A.

6.0 Poor functional suitability and configuration of the site

In addition to its poor condition, the estate of Jersey General Hospital is inappropriately configured to deliver safe and effective care. The condition of the buildings and poor layout of the site make it a challenging environment to deliver 21st century care. This poses many challenges in terms of delivering healthcare services at the hospital safely, to a high clinical standard and efficiently.

Consequently, it is not considered appropriate to plan to continue to provide clinical services in the existing hospital given that it fails to meet current building and operational standards, nor can it safely and effectively cater for the projected clinical demand.

In particular, there are increasing levels of operational risk, actual in-service failure, and elevated operational cost due to following:

- The existing provision of functional types, sizes and relationships of rooms do not meet current UK healthcare design guidance, space standards and current best working practices.
- The existing provision of the numbers of beds available and the provision of single bedroom accommodation does not meet current emergency demand, nor projected future daily demands whilst operating at recognised best practice occupancy rates.
- The constraints imposed by an estate comprising a disparate collection of buildings and associated building services' infrastructure of varying vintages from the 1800s to the present day, lead to inefficiencies in linking the various clinical services throughout the hospital and restrict the opportunities for adapting the existing facilities to meet current and future demands.
- The alteration and refurbishment of the existing buildings will never, as a consequence of the inherent condition and compromises in space and clinical adjacencies, allow the same level of benefits to be secured as would be possible in the development of a replacement hospital.

Ad-hoc development of the hospital historically has resulted in a number of poor adjacencies between departments. The layout of the hospital is not conducive to efficient or high-quality healthcare, with significantly large distances between departments that would benefit clinically from being adjacent.

This is both inefficient, involves the public transfer of patients, presenting real privacy and dignity issues and also represents clinical safety and risk issues given the distance with which patients need to be transferred. For example, the current JGH delivers poor adjacencies between diagnostics (such as imaging) and the departments such as Inpatients and Emergency. This increases travel times for both patients and staff, which can be crucial in emergency situations, but which also reduces efficiency day-to-day.

The age and the piecemeal construction of the site has resulted in a lack of flexibility. There is very little generic space that could be used to support changes in services and models of care over time. This means that changes to services require expensive and suboptimal capital developments that have to fit around existing buildings. This limits the potential for future service development as well as the potential for new technology and innovation. It is therefore acknowledged that clinical adjacencies cannot be addressed on the site without major reconfiguration or redevelopment.

The impact of poor adjacency therefore includes:

- Patients' journeys around the site being below expected standards.
- An increased cost for portering services and ambulance services needed to transport patients safely.
- Increased clinical risk, in particular due to the lack of adjacency between critical departments such as ED, maternity, theatres and Intensive Care Units.

Despite significant elements of urgent capital investment, the condition of the hospital has continued to deteriorate in recent years. Alongside this, the hospital has had to contend with increasing activity driven by population change and a general increase in the expectations of islanders. As a result, the pressure on the hospital has never been higher with aspects of poor condition and spatial organisation hampering performance.

The impact of this on the hospital and patients includes:

- Poor privacy, dignity, and patient experience
- Only a minority of patients having the choice of a single room - this may have a particular impact on some groups of patients and limits choice to all patients admitted.
- Infection control is severely hampered by the lack of isolation facilities.
- A poor ability to use space flexibly, in part due to issues with access to toilet facilities.
- Large bays in typical wards are difficult to clear without having a major impact on bed availability.

The following headline issues that have been identified remain of significant concern for the provision of health and care services and the urgency for these issues to be addressed is increasing over time:

- The inefficient and aging design of the estate has led to poor clinical adjacencies.
- There are poor space standards which are compromising effective care delivery.
- There is a lack of flexibility to accommodate service delivery.
- There is poor separation of clinical and non-clinical flows.
- There is poor gender separation and lack of privacy.
- There is poor supporting mechanical and engineering infrastructure.
- There is poor fire compartmentalisation to allow progressive horizontal evacuation.
- Maintenance costs are continuing to escalate, as mechanical and electrical plant reaches the end of its useful life.

The current configuration of the site means it is not set up to meet these requirements and would need significant redevelopment and change to be in a position to deliver this ambition properly.

These spatial dilapidation difficulties cannot be addressed through piecemeal replacement of building elements and a complete redesign of the hospital will be required to meet the current future acute clinical needs of the population.

In the absence of this, pressure will continue to grow and the hospitals overall contribution to transformation strategies such as the new care models, or the Digital Strategy, will be impaired.

7.0 Poor resilience

As detailed above, there is an increasing risk of infrastructure failure to a considerable proportion of the existing campus. Without careful management this would potentially therefore impact on the safe, effective, and consistent delivery of operational services and ultimately therefore care for patients. Whilst there is ongoing management to mitigate the risk of failure to the physical environment, this cannot eliminate the risk of a serious failure i.e., hot water services.

8.0 Why the current arrangements are not fit for purpose

The new healthcare facilities need to deliver a meaningful change to the delivery of health services in Jersey and deliver a hospital which is fit for purpose today and in the future. Based on the analysis, there is a clear case for change:

- The condition of the estate is poor and presents significant challenges that will increase in around five years' time. Facilities are in poor conditions with the worst affected areas of the building presenting daily operational difficulty. Some aspects of the hospital are in such poor condition that the risk of failure is increasing.
- In order to achieve the expected benefits of more effective ways of working and/or new models of care, a significant change will be required in the way hospital services are delivered.
- Reconfiguration of the current buildings will, in nearly all aspects, require significant refurbishment costs to address infrastructure issues and high ongoing lifecycle expenditure whilst at the same time not addressing the inherent space, clinical flow and adjacency issues.

There is an exciting vision for the new healthcare facilities which can support and enable change across the way health services are delivered in Jersey as well as providing a hospital facility which is fit for purpose and delivers Value for Money to the people of Jersey.

9.0 The Estates Team

The HCS Estates team comprises of seventy-five staff across four sections that include Projects, Building, Mechanical and Electrical services. The split here is 10 Civil Savants

and 65 Manual Workers.

The day-to-day function of the team is to carry out planned and reactive maintenance tasks. This includes medical equipment maintenance, building services and infrastructure compliance.

Over the past 5 years the role of the department has grown, and the team are seeing more Capital investment need, and this is ultimately moving the team into construction project delivery.

The revenue budget for the Estate team is £10.5m p/a with approx. 50% of that budget covering staff pay, £1.7m on service contracts and the remaining being split onto maintenance for the entire healthcare estate. This equates to approx. £300k per discipline.

As a footnote in 2022 the Estates team undertook 12,450 reactive callouts.

10.0 Capital Investment find Risk Management

To support the ongoing need to heavily invest in the Health Estate an annual Capital fund of £5m, until 2026, has been secured to deliver a risk-based Infrastructure Improvement Programme, commonly referred to as a Backlog Maintenance Programme.

The HCS Estate team have collated over 100+ known infrastructure issues, from data collated from the 2019 Six Facet Survey, design feasibility reports and local site knowledge.

Risks impacting the infrastructure or clinical estate that require investment are captured on a live Risk Register managed by the Estates team, that in turn feeds the HCS corporate Datix risk management system. With ongoing review at fortnightly meetings this register is curtailed to service demand and risk-based improvements.

The Estates team are supported by external professional design teams.

As the hospital is a live environment with little to no decant space available, the need to close inpatient wards are critical to the maintenance plan. Closing large areas of the hospital i.e., a whole ward, gives the opportunity to deliver the required upgrades in a timelier and cost-effective manner.

Each November the Estates team confirms the following years project list, via signoff from SLT.

Over the last 5 years the Estates team have successfully completed over one hundred risk related projects / tasks.

Some of the more substantial of these being:

- Full remodelling of the Maternity dept.
- Lift Replacement, 1 x Dirty Lift + 2 x Bed Lifts (General Hospital - 006 Block A, Parade Block)
- Emergency Lighting. All patient areas require emergency lighting, to back-up essential lighting circuits.
- Five Oaks Energy Centre replacement
- Fire stopping find compartmentation works.
- Endoscopy Ward Refurbishment
- Sorel Ward Refurbishment
- Plemont Ward Refurbishment
- Samaras Ward Refurbishment

- Medicine Room Refurbishment x5 Wards for Pyxis Robot dispensers.
- Hospital Canteen
- Multiple Air Handling Plant replacements
- New Operating Theatres
- New PCR Labs
- Jersey Hospital Nightingale Wing* (not backlog monies)
- New MRI Scanner
- New CT Scanner

END OF REPORT