Health and Community Services Department Advisory Board

Health and Community Services

Date: 4 October 2023	Time: 9:30 – 2:30pm	Venue: Main Hall, Dumaresq St, St Helier, Jersey JE2 3RL

Board Members:		
Professor Hugo Mascie-Taylor - **CHAIR**	Fixed-Term Chair of the Board	**HMT**
Christopher Bown	Chief Officer HCS	**CB**
Carolyn Downs	Non-Executive Director	**CD**
Anthony Hunter	Non-Executive Director	**AH**
Patrick Armstrong	Medical Director	**PA**
Jessie Marshall	Chief Nurse	**JM**
Claire Thompson	Director of Clinical Services	**CT**
Andy Weir	Director of Mental Health Services and Adult Social Care	**AW**
Anuschka Muller	Director of Improvement and Innovation	**AM**
Cheryl Power	Director of Culture, Engagement and Wellbeing	**CP**
Steve Graham	Associate Director of People HCS	**SG**
In Attendance:		
Obi Hasan	Finance Lead – HCS Change Team	**OH**
Simon MacKenzie	Medical Lead – HCS Change Team	**SMK**
Cathy Stone	Nursing and Midwifery Lead – HCS Change Team	**CS**
Beverley Edgar	Workforce Lead – HCS Change Team	**BE**
Emma O'Connor	Board Secretary	**EOC**
Bob Scullen	Business Support Officer (Items 1 – 13 only)	**BS**
Sophie Bird	Head of Communications HCS	**SB**
David Hopkins	(Interim) Chief of Service Women, Children and Family Care (Item 18 only)	**DH**
Jonathan Carter	Head of Estates (Item 29 only)	**JC**

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

HMT welcomed all to the meeting, including members of the public and the newly recruited Non-Executive Directors (NEDs). This first meeting with independent members is an important day as the overall purpose is to improve healthcare (as much a possible) for islanders and visitors to the Island.

HMT acknowledged the hard work of the Minister for Health and Social Services (MHSS), Deputy Karen Wilson, in establishing this Board. It has been her consistent support and energy which has driven this forward. Unfortunately, the MHSS is unable to attend in person today primarily due to a sitting of the States Chamber but also an episode of illness.

The Board will be made up of a Chair, five NEDs and five Executive Directors, all with voting rights. CB is in the process of determining which five Executive Directors these should be, and the proposition will be discussed the Chair and the MHSS.

Board meetings will be guided by openness and transparency so that members of the public understand what has been achieved, what cannot be achieved and the future plans for the healthcare services that they fund. All issues will be discussed in a meeting in public unless there is a good reason not to, i.e., legal process, commercial sensitivity or identification of an individual. The meeting will be recorded and minuted, both of which will be available to the public. It was acknowledged that this is a learning process for all. The HCS Change Team have been invited to today's meeting as the papers are a collective contribution.

HMT advised that due to the large number of agenda items, all papers would be taken as read and asked Executive Directors to draw the Board's attention to important issues with a focus on outcomes and compliance, rather than a description of process.

Apologies received from: Dr Clare Gerada Non-Executive Director CG	

2	Meeting in Public - Conduct	Action
Paper taken as read. Noted that primarily, a meeting in public provides an opportunity for members of the public to ask questions (written and verbal). EOC suggested that the written questions should be submitted no later than two working days before the meeting, rather than three, to allow individuals sufficient time to read the papers. The was agreed by the Board.		

3	Declarations of Interest	Action
No declarations.		

4	Minutes of the Previous Meeting	Action
The minutes of the previous meeting held on 10th July 2023 were agreed. The minutes of the previous meeting held on 23rd August 2023 were agreed.		

5	Matters Arising and Action Tracker	Action
ACTION 49: CB advised this is progressing well – the Project Management Office (PMO) is starting to form. Whilst not all posts are recruited to, CB confident that this will take place. Agreed **CLOSE**. **ACTION 47:** It was noted that the extraordinary Board meeting on 23rd August 2023 was convened to address this (minutes approved in item 4 of this agenda). **Agreed CLOSE.** **ACTION 37:** HMT has discussed benchmarking with the MHSS, and the view is to find appropriate benchmarks (likely from the UK but, if necessary, elsewhere) and use these to measure HCS against this standard. CT drew the Board's attention to the Maternity paper (item 18 on the agenda) with a proposed suite of metric for Maternity which are in line with UK benchmarks for Maternity Services. CS also advised the Board that HCS is progressing a professional relationship with an integrated care board (ICB) in the UK which receives the majority of HCS patients and benchmarking aligns. CT advised that HCS is confident it has the ability to collect this data and benchmarked information will be available at the Board next month (November meeting). It was agreed that due to the high profile of Maternity Services, the Board will review the Maternity data monthly. Agree **CLOSE**. **ACTION 31**: OH explained that the lack of budgetary information available to budget holders has been tracked over the last six months. Following the implementation of the new system, access rights were changed. The HCS finance team have been told that work to resolve this has been delayed with a revised timeframe of Quarter 1 (Q1) 2024. The HCS Finance Business Partners have limited access, it is the wider access across HCS that will take time. CB noted this was not a satisfactory position. To mitigate the risk associated with this lack of access, the finance business partners download the information and produce reports for budget holders. However, this is an inefficient (manual) process. OH provided assurance that there is a process in place to hold budget holders to account for management of their budgets including weekly meetings with the care groups and the care group performance reviews. The Board asked to be provided with an update at the meeting in December Remain **OPEN**. **ACTION 25**: EOC explained that meetings are taking place with the Government of Jersey (GOJ) Internal Audit (IA) to ensure that the terms of reference for the HCS Audit Committee align with the IA function. Following this, the HCS Risk Management Committee Terms of Reference will be reviewed to ensure there is no duplication. Agree **CLOSE**. **ACTION 23**: SG advised that once the Statutory and Mandatory training Matrix is approved (item 27 on the agenda), this can be shared with the Group Director People and corporate Services		

(PCS). It can then be agreed that HCS staff will not need to complete the Corporate Induction which will be superseded by HCS training (thus avoiding duplication). The Board noted it's thanks to Group Director PCS for taking this approach. Agree **CLOSE**.	

6	Chair's Introductions	Action

HMT invited both CD and AH to introduce themselves as newly appointed Non-Executive Directors (NEDs).

CD informed the Board that she is a recently retired local authority Chef Executive Officer. Previous appointments include,

- Chief Executive Officer (CEO) of the London Borough of Brent.
- CEO of the Local Government Association which is the National Body for all Councils in England and Wales.
- Deputy Permanent Secretary at the Ministry of Justice.
- CEO of Shropshire County Council

Current posts include,

- A NED for the largest four acute NHS Trusts in the UK which work as a collaborative in Northwest London and hosted by Imperial College NHS Trust.
- A member of the London Policing Board appointed by the Mayor of London to monitor the improvement of the Metropolitan Police.

Anthony Hunter (Tony) informed the Board that he is a Social Worker by background, working in Health and Social Care for the totality of his career in a range of different roles across private, public and charity sectors. Previous posts include,

- Chief Executive Officer of the Social Care Institute for Excellence, an improvement agency for Social Care and Health, working closely with the Department of Health and Social Care and the Department for Education.
- Chair of two Children's Trusts in areas where the responsibility for Children's Social Services had been taken away from the Council for persistent failures.
- Director of Social Services in two Councils
- Chief Executive in a third Council
- President of the Association of Directors of Social Services in England

Current posts include,

- Chair of the Berry Metropolitan Borough Council Adult Function
- NED for a Hospice in Southeast London
- NED for a Charity for Functional Neurological Disorder Action UK

Noting CG's absence (see apologies), HMT informed the Board that CG is a General Practitioner and currently the President for the Royal College of General Practitioners (GPs) UK. Previous posts include a plethora of roles across the National Health Service (NHS) at National level.

HMT informed the Board that he was a Consultant Physician in Leeds, moving into various management roles including,

- Medical Director in Leeds (was the largest Trust in the UK at the time).
- Interim Chief Executive Officer
- Variety of roles in provisioning and commissioning at local, regional and National level. This includes Trust Special Administrator at Mid-Staffordshire.
- Clinical governance reviews including Australia, Middle East and most recently, Jersey.

One of the recommendations of the Jersey report is the establishment of this independent Board. HMT's fixed-term contract ends end-November meaning that he will act as Chair at one further meeting. The process to recruit his successor is underway.

7	Chief Officer's Report	Action

CB took the paper as read and advised the Board that the purpose of the report is to summarise the key issues that HCS faces. These issues are covered by fuller reports as part of today's agenda and aim to reflect the three pillars of the HCS turnaround work:

1. Strengthening of clinical governance and clinical services,
2. Financial improvement and financial recovery,
3. Cultural change.

The aim of these is to improve health services for the people of Jersey.

Both CD and AH thanked CB for the report, noting the issues will be covered more fully later in the agenda. In addition, AH noted it was very useful to understand the issues that matter to CB as the Chief Officer and direct the Boards attention.

8	Quality and Performance Report Month 8	Action

HMT suggested that the Board's approach to this report should be those metrics that are continuously red and request a clear plan of action to resolve.

1. **New to follow up ratio (outpatients)**
   HMT asked if the standard ratio of 2 is an appropriate benchmark (compared to other health jurisdictions) to which there was agreement. Noting that HCS has never reached this target, HMT asked what is being done about this and when does HCS expect to reach 2. CT advised this is a complex issue attributable to specific specialities (urology and dermatology as examples), the detail of which is presented and discussed at the care groups performance reviews to assure the Executive Directors regarding utilisation of clinical capacity. However, this data is affected by patient pathways in Jersey which require patients to be on a waiting list for annual surveillance (as they cannot be followed up in primary care as would be in the UK). All speciality outliers of this metric are considered as part of the clinical productivity work in support of the financial recovery programme, providing an opportunity to review other health jurisdictions practice.

   CB asked CT how much of the PTL is impacted by keeping patients on a hospital pathway, rather than discharging to Primary Care as would be common in other health jurisdictions. Secondly, are there specific speciality outliers that can be targeted, the impact of which would see the ratio reduce. In the absence of specific detail, CT is confident that the inability to follow up in Primary care significantly impacts the PTL.

   HMT suggested that HCS must be clear that there are very good reasons for not meeting targets i.e., HCS should benchmark against other health jurisdictions and if unable to do so, then it must be explained to the Board why not. Following this, if HCS continues to use 2 as the standard benchmark, what is the trajectory to achieve this?

   CD in support of this approach and adds that it is difficult to ascertain from the report what is improving (difficult to understand any long-term change) and what are the actions being taken. Of all the red metrics, what are the most important issues and what is being done about these? CD suggested that if there is a specific focus on these areas, hopefully an improvement would be noted over the following months which is more motivating for staff to see their efforts making a positive impact.

   In addition, CD noted her concerns about the quality of the performance data and asked how confident HCS is (as the report seems to imply the opposite).

   AH said it would also be useful to understand what variance was anticipated and what was the learning, to inform practice in future years.

Areas of focus,

1. **Elective Theatre Utilisation**

2. **% triaged within target – majors**.

   CT advised the Board that this data is not correct (as detailed in the exception report) and has received assurance from the care group management team that all patients are being triaged within the defined standard. HMT asked to see the corrected figure in future reports. CT advised there are ongoing discussions with the Clinical lead in the Emergency Department (ED) and the HCS Informatics team as to whether this data can be split according to the different triage categories of majors patients.

3. **% patients waiting over 90 days for 1st OP appointment – community**
   Although the data is red for acute services, CD noted that community services are much further away from target than acute services. What is the cause of this?

   CT advised the Board that the improvement seen in the outpatient community PTL has been achieved through the commission of Community Dental Services for Children (Social Recovery Scheme following Covid). Capacity within the HCS Dental Department is not sufficient to see all children in Jersey. In addition, dental was particularly affected by the impact of infection control measures through Covid. The detail of this work can be found in the paper under item 19 (Waiting List Report). The development of an Oral Strategy for Jersey will be key to understanding what services HCS will need to provide for children which is not currently part of business as usual (BAU) capacity.

   CD also remarked that diagnostics is significantly deteriorating. Noting SMKs comment that not all diagnostic functions are captured in this data (excludes radiology), CD asked if this makes the position better or worse. The current wait for routine MRI scan is 44 weeks and CB reported there is a plan to reduce this to 6 weeks by Christmas 2023. Whilst accepting there are areas of challenge and improvement, CT assured the Board that the rise in the diagnostics waiting list is not real and this is a reporting issue following the implementation of Maxims (electronic patient record).

4. **Rate of emergency readmission within 30 days of a previous inpatient discharge.**
   CT advised that the deep dive of this metric has been provided at a previous Board (2022). Broadly, HCS benchmarks well. Noting that HCS benchmarks well, CD asked if the target is correct? SMK noted that although HCS was within the benchmark for England, case-mix change is not understood in the absence of coding data.

ACTION: Copy of the readmission deep-dive to be sent to the NEDs.

SMK advised the Board that if changes are made to the data, a supplementary paper should be submitted to the Board explaining what has been changed and why, to provide confidence that the Board understands what is being measured. HMT advised that this information is equally important to the management of HCS because if an organisation does not understand or have confidence in its data, how can it be managed.

AH advised the Board that himself and AW have already discussed the key performance indicators (KPIs) to be expected from a well working social care system as the current suite of metrics is under-developed.

ACTION: AW will lead the work to further develop the suite of metrics for social care, supported by Andy Weir, Director of Mental health services and Adult Social Care. The proposal to be presented at a future Board meeting (date to be advised by AW).

ACTION: Executive Directors to review the current suite indicators, standards set and quality of data to provide assurance that the data is meaningful and directs activity (date to be advised by CB).

ACTION: Executive Directors to provide a focus in the next meeting (November 2023) on the areas highlighted above:

- elective theatre utilisations,
- % triaged within target – majors
- % patients waiting over 90 days for 1st OP appointment – community
- New to follow up ratio.

ACTION: To determine who is accountable at Executive level for the exception reports detailed at the back of the Quality and Performance Report (December 2023).

CB / SMK gave a brief verbally summary of the work being undertaken with the Informatics Team to ensure that the content and format is appropriate, including the addition of statistical process control (SPC) to better explain any variation. HMT asked that any variation in format of the report is detailed in a paper for the Board to approve.

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

OH explained at end Month 8,

- Overspend of £18.9 million (rising by 2.8 million in-month)
- Year-end forecast remains £29 million overspend. Three main drivers of the overspend are pay, non-pay and income.
- The true position of the underlying problem is £35 million, which includes non- recurrent funding of £6 million pounds that has been drawn away.
- Agency pay is very high to recruitment challenges. There are 205 agency staff against 516 vacancies.
- Pay represents an overall £5 million overspend. However, this masks the underlying reality of the pressures which are mitigated by underspends in other areas. Key pressures are in the key clinical services: Medicine, Surgery, Women and Children, Mental Health placements, Social Care packages.
- £13 million pound year-to-date overspend on non-pay, increasing to £22 million by year-end. The area of non-pay is made up of a number of large contracts including Mental Health and Tertiary Care.
- Opening budget pressures of £13 million pounds. Part of the financial recovery work has looked to discover why this budget was not available to services already being provided.
- Income under-achievement of £2.7 million: this has been impacted by theatre underutilisation and reduced bad capacity.

OH highlighted that the finances of the organisation are a consequence of the actions taken to deliver care. The better and more efficient that care be delivered, the better the quality of care delivered which will also directly improve the financial position. This is what the financial recovery programme is based on – a set of core values which looks at the actions that can be taken to improve the quality of care and deliver better value for money. Recruitment of substantive staff is key.

The Financial Recovery Plan that has been developed will address the deficit for HCS sustainably over the next three years. An external consultancy firm was used whilst HCS built its own capacity to continue to deliver the FRP over the next three years (those factors within the control of HCS). Of the total deficit, £25 million is within the control of HCS through improvement in process, activity and recruitment. However, £10 million is outside the control of HCS and requires permanent funding – this has been accepted and agreed by Treasury. Key to the delivery of the £25 million over the next three years is culture change, accountability and ownership, and leadership. However, HCS must deliver £3 million in-year savings.

CD asked what progress has been made against the £3 million in-year saving target. In addition, noting the low number of reserves, CD also asked if the States of Jersey has larger reserves which can be called upon if a catastrophic event were to occur. Also, has the 2.93 million reserve been frozen in case the three million in-year target is not achieved?

OH responded that the reserves have been frozen to mitigate the risk of an unforeseen event compromising the £3 million savings.

Regarding assurance that there are sufficient reserves that HCS can request in extreme circumstances, CB and AM explained that the Government of Jersey and Council of Ministers (CoM) would determine how central reserves could be used. There was general agreement that a sufficient reserve for HCS would be 10% of its annual budget, £28.6 million.

AH noted it is important to remain open and transparent about what would happen if the financial targets were not achieved and how this could impact upon quality of care. OH provided assurance that before any financial recovery scheme is implemented, a quality impact assessment is carried out with clinician engagement. However, it is key to note that there are financial limits to what services HCS can deliver.

10	**Workforce Report Month 8**	**Action**

SG took the paper as read and highlighted some key points for the Board.

- There has been a significant increase in the funded establishment over the last 6 months due to Government Plan work and the development of new services. Whilst the number of staff in post has also increased, the differential between the increase in funded establishment and staff in post has led to a higher vacancy.
- Recruitment is a focus for work and activity with additional capacity to support the recruitment process, redesign of the process and targeted recruitment activity and campaigns. There has been successful recruitment following the redesigned campaigns to attract candidates.
- The increase in turnover rate can be accounted for by the Junior Doctors rotation in August. The voluntary turnover rate (resignations) is stable at approx. 4%. There is no evidence that there is a larger turnover of staff. However, as there are small teams in Jersey, if an individual leaves, this can have a big impact upon the team.
- The sickness absence rate has remained constant over the last quarter with the main reason for sickness as coughs / colds.
- A new system was introduced at beginning of 2023 to record staff appraisal. HCS has and continues to experience system and access issues, leading to a low reported rate of appraisal completion. As of this week, 19% staff have their objectives agreed, with 9% completed the mid-year review. The GOJ HR team are providing a lot of support to HCS to overcome these issues.

HMT invited JM to give an overview of nurse recruitment.

- In process of producing a micro-site for nursing colleagues which includes midwifery, mental health, general and speciality nursing. The focus of the microsite is what Jersey can offer in terms of career development, training and education. The site should be live at the beginning of November 2023.
- In the interim, HCS has been working with agencies to find substantive staff in those hard to recruit areas. There has been progress in some areas.
- The additional capacity (mentioned above) is supporting the recruitment process to be carried out in a timely manner.

HMT invited BE to comment. BE noted that the development of the microsite is a breakthrough. It is also recognised that the UK market is the richest market for staff. Due to the vacancy rate in the UK, this is now a very competitive market. As HCS is not OSCE ready, the overseas market cannot be pursued (due to the amount of money this would cost).

CB noted that the shortage of staff (both substantive and agency) in some areas, impacts upon waiting times, for example, in Mental Health Services – psychological practitioners. AW echoed the importance of highlighting development opportunities for staff, particularly in the redesign of services and roles.

AH would like to understand the different recruitment strategies considering ethnic origin, age, disability, gender etc. and what HCS is learning about effective recruitment and retention strategies in Jersey.

ACTION: AH to email HMT above list and HMT will pass this onto Board members to be answered. SG to respond at next Board meeting (November 2023).

CS advised the Board that Jersey has signed a contract with a facility in the UK for the continuation of training and education of Registered Nurses. The UK are exploring the role of the Nursing Associate, and this is an opportunity that can be exploited in Jersey to develop staff (for which there is an appetite).

CD noted that recruitment difficulties are a theme that run through most of the reports and suggested it would be helpful for the Board to receive a report in November / December which looks at the longer terms approach to recruitment across the whole service. This may also support recruitment across wider Government.

ACTION: The Board to receive a report detailing the longer-term approach to recruitment across HCS (December 2023).

SMK advised the Board that recruitment of Doctors is also experiencing significant challenges which may lead to decisions about service continuity. However, it is important to appoint the right candidates, and, in some circumstances, it is appropriate not to appoint.

Following a discussion regarding the data for those who have left HCS, SG advised that he intends to bring the analysis of exit interview data to a future Board meeting.

ACTION: SG to bring a paper detailing the analysis of exit interview data to the next Board meeting (November 2023).

Noting the lack of flexible working as a reason for leaving, AH commented that it is important to set expectations initially and how the function of the microsite will be key to this.

11	**Serious Incident (SI) Position Statement**	**Action**

PA took the paper as read. It was acknowledged that HCS is not in a position it would like to be as regards to timeliness of investigations and assurance regarding lessons learned.

Changes have been made including the governance around SIs. There are challenges in identifying investigators (both internal and external). The challenges to identifying internal investigators include job planning process and time away from clinical activities. For assurance, safety huddles are convened following an incident to identify any immediate learning.

The Quality and Safety team have undertaken a piece of work to collate all the learning from incidents. Assurance regarding the learning will be a feature of the care group governance meetings which will be starting soon.

To overcome the challenge of identifying investigators, the SLT will be asked to consider a proposal to appoint individuals to investigate all incidents, with support of specialist clinicians when needed. General discussion followed regarding professional responsibilities to learning and the potential appointment of investigators does not remove this responsibility. General agreement that investigating an SI is a valuable Continuing Professional Development (CPD) opportunity.

CD noted this report raised a number of serious concerns particularly in relation to those SIs where an investigator has not yet been appointed. Of these, how many relate to serious incidents of harm and if necessary, should an external investigator be appointed for a timely investigation and learning. Drawing on previous experience, CD noted that she has never seen that SI investigation is not part of individuals jobs i.e., these are usually allocated and turned round quickly to understand the learning. PA clarified that HCS has commissioned external

investigators for those SIs where there has been a significant delay in sourcing internal investigators.

Regarding the inclusion of SI investigation in job planning, CD stated this should be done as a matter of urgency. In addition, themes, service areas and outcomes should feature in future reports. PA responded that the main themes are lack of recognition of a deteriorating patient and lack of escalation once deterioration has been identified. There is a particular focus now on Massive Obstetric Haemorrhage (MOH). Job planning will be addressed later in the agenda.

CB noted SIs are an area of concern for the HCS Senior Leadership Team and a monthly report is received. CB also drew the Boards attention to the cultural issues within HCS as staff are reluctant to undertake SI investigations due to the size of the organisation. General discussion highlighting that SIs are about learning and preventing future harm, not apportioning blame. A discussion followed regarding a culture of attributable justice rather than restorative justice and how this has contributed to reluctance of individuals to investigate.

ACTION: Future SI papers to include the themes that arise for SIs, the changes that need to be as made as a result of these themes, who is responsible for enacting the change (at Executive Director level), and how do we know that the change has occurred (December 2023).

It was agreed that SI investigation is a crucial process that improves the quality and safety of care for patients.

12	**Complaints Position Statement**	**Action**

Paper taken as read. Key points include,

- This is the first report since the change in structure within the Patient Experience Team.
- Trend analysis has been limited by system issues, but this is expected to be resolved and therefore included in future reports.
- Early closure and resolution were a focus during August with support from the Patient Advisory Liaison Service (PALS).
- At the time of writing the report, there were 80 open complaints. This has reduced to 51 at end of Sept (unvalidated data).
- Key themes of complaints included appointment letters and do not attempt cardiopulmonary resuscitation (DNACPR). Targeted learning has been identified for action.
- There are six legacy complaints which cannot be closed for reasons including, legal services review and external investigation.
- Compliments have been received through the My Experience Survey. This will be changed soon to the Friends and Family Test which is expected to produce more useful data.
- In discussion with the Picker Institute regarding the planned launch of the survey in November 2023. This will cover inpatients, urgent and emergency care, maternity and community mental health. JM proposed bringing back the outcomes of this to the Board in 2024.

ACTION: The outcomes of the Picker Survey to be presented to the Board (JM to advise on a date).

AH noted an emerging theme of organisational learning from the papers received this morning and highlighted it is encouraging to see HCS emphasise this. In addition, how well does HCS understand patient experience and what is being done to improve this when standards are not met.

13	**Waiting List Report**	**Action**

Paper taken as read. Although not directly addressed in the paper, CT emphasised that the impact of waiting for care upon individuals and their families is part of the workstream to improve access to care and treatment.

The implementation of the new Electronic Patient Record (EPR) in May 2023 has affected the waiting list position (PTL) for inpatients, outpatients and diagnostics. Firstly, CB commented on the importance of resolving the system issues to understand the true PTL position. Secondly, CB noted that it is important for patients to understand how long they will have to wait, rather than the total number of patients on a waiting list. Funding (5 million) has been provided by the GOJ to insource / outsource additional capacity to recover the waiting lists and procurement of these services is following the GOJ process. Once the backlog is recovered, the challenge for HCS will be to maintain the waiting times which will require a review of medical / surgical pathways and theatre utilisation. The increased waiting times are a symptom of many issues. ACTION: The board to receive a report at the next meeting detailing the progress of spend of the £5 million, to include reasons for any delays (November 2023). Noting the individuals deemed 'urgent' who have been waiting > 90 days, CD asked what assessment of harm is undertaken as a result of the wait, does the cost of treatment then rise as a direct consequence of this wait and is there any data regarding the conversion of those on a PTL seeking treatment as an emergency. CT responded that harm reviews (physical / psychological) were a key feature for HCS coming out of the Covid pandemic. Any incidents of harm followed the organisational policy for patient safety incidents. However, there is no data to understand how many patients on the PTL convert to emergency admissions. PA commented that the harm review that is in place could be strengthened. ACTION: HMT asked for there to be a focus on six of the areas where patients experience long waits and detail the constraints, how these are managed and the timeline for resolution (December 2023). It was agreed that the current position is unacceptable, and the Board needs to understand what is being done to address this through six areas which could include MRI, endoscopy, ophthalmology, dermatology and lower limb.	

14	**General Surgical Acute Rota**	**Action**
PA provided a verbal summary following concerns raised at the last meeting regarding the sustainability and safety of the general surgical on-call rota (at Consultant level). PA advised the Board this is an example of the challenges of a small health jurisdiction, such as Jersey, in providing emergency and urgent on-call services. PA provided the background of the rota and changes that have been previously made following concerns raised by the Consultants and increasing sub-specialisation. Work has continued within the surgical department to develop the on-call rota. The current challenge is sustainability of the on-call rota and whether there are enough senior Doctors (Consultants) to cover, whilst exposing them to the number of patient required to maintain skills in this area. One possible solution is to commission a Royal College of Surgeons review and to understand how the service is delivered in similar jurisdictions. HMT advised it was important for the Board to be assured and supported PA's suggestion for an external review to understand if HCS is doing the best it can and if not, what should / could we do. ACTION: PA to report on progress in commissioning external reviews (November 2023)		

15	**Job Planning**	**Action**
Paper taken as read. The process for job planning has been more difficult than anticipated due to a number of factors including the lack of requirement for job planning previously and less emphasis on what HCS needs from individuals and rather more emphasis on how individuals wish to work.		

The previous deadlines for completion of the process have not been met (July and September 2023). However, in areas with Doctors that have recently come from the UK where job planning is BAU, the process has been much quicker, for example the Emergency Department.

There has been an improvement since the paper was written with just over 50% with an in-date job plan with an anticipated increase to 90% over the next few months. However, as this process is not embedded, there is an expectation of more appeals than normally would be expected. Appeals are addressed through a consistency panel.

CB observed that this is another area where culture is key, and individuals must be held to account for the care provided. Some of the conversations taking place reflect the conversations that were held in the UK when job planning was first introduced circa 30 years ago.

However, job planning is key for both HCS and the public of Jersey to be clear about the services delivered. The use of taxpayer's funds needs to be clear, particularly in relation to the use of Supporting Professional Activity (SPA) time. Job planning is a contractual requirement of all Doctors.

Referring to potential financial gains / losses mentioned in the paper, PA explained this is due to historical timetabling where individuals are found to be working hours that are not considered safe: the reduction of hours would have a consequential loss in income.

HMT stressed the advantages of job planning for both HCS (probity, planning clinical activity, provision of safer services) and individual Doctors (openness and protection against unfair criticism). From a financial perspective, OH very supportive of the process as job planning delivers many productivity benefits. Considering the current recruitment issues, HCS needs to maximise current capacity which can be done through job planning.

The Board agreed that job planning is a matter of urgency for HCS.

ACTION: PA to provide an update paper at the next meeting (November 2023).

16	**National Institute for Health and Clinical Excellence (NICE) / Royal College Guidelines**	**Action**

PA advised that the HCS SLT agreed to adopt NICE guidance as the default position for clinical guidelines. This does not mean that NICE was not being used, rather this is now a clear statement that sets expectations.

Currently, HCS is not able to provide assurance to the Board regarding compliance. However, a piece of work to address this is planned for early next year. A process has been developed for any new guidance that is issued to ensure that it is incorporated into HCS practice.

CB emphasised the decision to adopt NICE (and other available evidence-based practice) is about improving safety of services and ensuring that clinicians are protected. Recognising that there may be legitimate circumstances where HCS cannot follow NICE (or other evidence-based practice), HMT stressed this must be discussed in an open and transparent way at the Board so that the people of Jersey know that they are getting what they should get as dictated by the scientific evidence and if not, it should be clear as to why there are not. For clarification, deviation from evidence based best practice is not a matter for individual arbitrary decision-making. Organisations across most industries manage patient safety through standardisation and systemisation i.e., not allowing random individualistic behaviour. SMK clarified that a process to manage this has been developed.

In addition, NICE was adopted as HCS clinicians are registered with General Medical Council (GMC) and are members of the Royal Colleges in the UK.

In response to HMT's question about the purpose of the Policy and Procedure Ratifying Group (PPRG), PA clarified that it is not about redebating any evidence-based practice, rather to understand what the policy is and that if it effects more than one care group, this has been

considered. Dr Hopkins reflected on the current process as a robust process with the required level of flexibility to adopt evidence-based practice. As a point of clarity, CS highlighted that the term clinician is not limited to Doctors, but also includes nurses, midwives, social care partners and allied health professionals (AHPs). ACTION: PA to provide a verbal update on progress so far at the next meeting (November 2023).	

17	Acute Medicine	Action
Paper taken as read. CT advised the Board that the Royal College of Physician reports have not been appended as they are being reviewed by Information Governance (to ensure that there is no patient identifiable data released). Pending this review, the reports will be appended to the minutes. The report describes areas of concern and the approach to improving these. To replicate the model being used in Maternity improvement (see item 18), a two-weekly medical improvement group will be established. Oversight is also provided monthly at the HCS Change Programme Board. The support and expertise of an external colleague has been commissioned following the RCP report with areas of focus to include improving Same Day Emergency Care (SDEC), the Acute Admission Unit (AAU) / Enhanced Care Area (ECA) and bed modelling. Access to beds is critical to the quality of care delivered to patients and impacts upon the elective programme and financial recovery. AH asked if there is a detailed plan in relation to this. CT confirmed there is an action plan, a summary of which can be provided at the next Board. In addition, where the report refers to additional funding, given that HCS is already in financial recovery AH asked how the Board should respond to this. CT responded that savings have been identified by substantiating already open beds which are staffed by locum / agency staff. Other work will feature in the financial recovery plan. CD noted the absence of social care considerations in the paper and asked whether the proposed business plan will consider potential capital investment in the community as a longer-term solution. CT responded that the Winter Plan is taking this approach. In addition, AW explained that a piece of work has commenced that is jointly led by social care, acute services and intermediate care to understand all delays i.e., what is the cause of the delay and what can be done to minimise this. The team meets weekly and initial analysis show delays due to flow – step down beds and availability of care packages for people. SMK gave an overview of the current bed position and advised that the average length of stay has increased by two days from 2019 to 2022, partly due to delays in transfers but also internal inefficiencies. However, there are advantages to both HCS and patients to increase the medical bed base, but this will come at a cost, potentially to the detriment of other services. In response to HMTs question, it was confirmed that substantive Medical Consultants are not carrying out daily ward rounds of patients. ACTION: HMT asked for future report to summary of action plan and detail which recommendations HCS intends to enact (in list form), with a timescale (November 2023). In support of these discussions, OH advised this work is critical from both a quality of care and financial point of view. However, the challenge is not what needs to be done, rather it is the culture.	

18	Maternity Improvement Plan (MIP) Workstreams	Action
DH was introduced to the Board as a Consultant Diabetologist and the Chief of Service of Women, Children and Family Care.		

Paper taken as read which highlights the significant concerns regarding maternity care as considered by HCS and external reviews that have been commissioned in the past. The aim is to improve outcomes and the care delivered to patients and their families.

All the recommendations from the variety of reports have been consolidated into one comprehensive action plan to facilitate a systematic approach to addressing these.

Led by the Executive leadership team, the Maternity Improvement Group (MIG) meets weekly with the Clinical leaders from the care group to review the recommendations and associated actions and escalate any issues. Of the 131 recommendations, 52 have been achieved to-date.

Appendix B demonstrated to the Board how the programme has good clinical engagement and support. A collective response from the department is key to achieving the improvement and sustainability. The recommendations in relation to the culture and relationships will be longer term.

As discussed earlier in the meeting (item 5), Appendix C shows the maternity dashboard, which details metrics to demonstrate safety of care. In response to CDs question, CT stated that the dashboard will be available from next month.

JM advised the Board that a substantive Director of Midwifery has been appointed and will in post on 11th December. There is currently an interim Head of Midwifery.

Noting the documented disproportionality in outcomes for women and their babies depending upon ethnic origins and affluence, the link to antenatal services and community services is exceedingly important. CD suggested that visibility of this link would be valuable in the dashboard i.e., number of women who do not attend antenatal appointments who then experience a still birth.

HMT asked how culture and interpersonal relationships are being improved in the Maternity department. CP advised the following,

- Five listening events with professional groups that sit within maternity have been carried out which has generated a number of themes. These themes have been used to develop further initiatives to address the cultural issues raised. Themes include,
    - Professional knowledge and skills not being respected.
    - Engagement between professional groups.
- Further initiatives include specific mediation to build psychological safety.
- A Civility Saves Lives approach to help people to understand that uncivil behaviours can have a negative impact on patient safety.
- Multi-professional training.
- Recruitment and retention of staff

DH advised that the culture change is recognised as a significant element of the improvement work.

ACTION: The Board to receive a monthly report with specific progress against the targets that have been set, including any general comments about culture issues.

19	**Infection Prevention and Control (IPAC) Audit Improvement Work**	**Action**

Paper taken as read. Key highlights,

- No outbreaks of healthcare associated infections (HCAIs) or C. Difficile (C. Diff) during August 2023.
- Overall compliance with hand hygiene is 93.2% across all staff groups (against a target of >90%).

CB advised it would be useful to see the staff uptake rate of vaccinations in this report and asked if there is any historic data. JM confirmed that HCS reports yearly on the flu / COVID vaccination uptake rates, and it was agreed that this can be included in future reports. HMT asked JM if there is an issue with compliance in Jersey. JM confirmed not and added that there are IPAC Champions on the wards, supported by the IPAC team. When monthly audit results yield a low compliance rate, the audits are carried out daily until required level of compliance is achieved. ACTION: Flu / Covid vaccination uptake rates to be included in the report at the next meeting (November 2023).	

20	**Appraisal and Revalidation for Doctors – Position Statement**	**Action**
From the outset, HMT advised that whilst appraisal and revalidation are processes of the regulator, this does not remove the responsibility from HCS (as the employer) for patient safety. HCS is responsible for ensuring that the people it manages are behaving appropriately and have required level of competence to remain safe. PA took the paper as read. Key highlights, • A difference between appraisal in Jersey and appraisal in the UK is the lack of useful information and data that feeds into the appraisal system, for example individual clinician wound infection rate, Datix data showing which incidents clinicians have been involved in. • The high-level responsible officer (RO) form the South of England recently visited to Jersey and provided advise and suggestions including having Deputy Responsible Officers (DROs) and a broader team to oversee the appraisal process. HMT stated HCS has a responsibility to provide relevant data to support the appraisal process. ACTION: The Board to receive an update in January 2024.		

21	**Cultural Change Programme**	**Action**
Paper taken as read and it was noted that culture issues are a common theme through most of the papers on today's agenda. Key points, • A positive cultural workplace enables better patient outcomes. • A GOJ wide BeHeard survey has recently taken place with a 28.5% HCS response rate. When compared to the 2020 survey results, growth can be seen across all eight factors of engagement. • Cultural needs are beginning to be understood following a series of listening events. • Key actions plans are being developed as discussed for Maternity (item 18). AH noted there is a lot of work taking place in this area and reminded Board members that culture is about thinking how our own individual behaviours impact upon others and the workplace. CD suggested it is a priority for the Board to see the improvement plan for culture in the next couple of months including what success looks like and differences that have been made. Over the last six months, CB stated that he has noted an increase in the number of staff speaking up, whether through the Freedom to Speak Up Guardian or himself. However, the Board agreed that culture change is a long-term programme, potentially 4-5 years. ACTION: The Board to receive the improvement plan for culture in December 2023 including what success looks like and the differences that have been made.		

22	**Management of Incidents of Racial Abuse**	**Action**

Paper taken as read. Following the cultural report received at the (shadow) board meeting, a report was requested detailing the action taken in response to 29 reported incidents of racial abuse.

Datix was used to retrieve the data and action taken was measured against the Unacceptable Behaviour Policy. Whilst there no reported incidents of racial abuse between staff members, CB advised the Board that it should not be assumed that it is not taking place: CB has received verbal descriptions where BAME colleagues have experienced racial abuse from colleagues.

There was evidence to show that actions taken were either appropriate or partially appropriate (both immediate and follow up). However, the recording of 'no harm' related to physical harm rather than the consideration of psychological harm. There was also limited evidence to show that staff were offered a debrief or support as a follow up when exposed to racial abuse. Some evidence shows that staff declined to report incidents of racial abuse to the Police.

AW advised this is a particular issues in acute inpatient Mental Health Services as evidenced through the 66% reported incidents in this area. AW explained whilst unacceptable, it is a complex issue because some of the guidance does not apply when detaining individuals against their will because they are acutely mentally unwell, for example you cannot ask them to leave the premises. Whilst there may be no initial harm (physical or psychological), AW is concerned about 'weathering' where staff are subjected to racial abuse daily with a consequential effect upon staff morale and HCS's ability to recruit and retain staff.

One individual has been successfully prosecuted for repeated racial abuse towards staff. Mental Health Services are working jointly with the Police to produce a Prosecution Policy which provides clear guidance when an individual is unwell but is breaking the law as to what to do. In addition, across both acute services and mental health services, the Police will be called to assist in an event but then staff decline to give any statement – this restricts the Police's ability to respond. Training will be a key part in the development of this policy.

AH noted that this links with respect for each other and the wider culture work that is needed.

SG advised the Board that at the point of recruitment, ethnicity is not asked. Consequently, there is currently no definitive data regarding the diversity of the workforce. However, as GOJ staff move to the new system (Employee Central), staff will be encouraged to update demographic information which will include ethnicity. This data will facilitate a greater understanding of the population affected by these issues. In addition, BAME was renamed as REACH as ethnic minority in Jersey is different as to what is seen in the UK. BE also highlighted that Jersey does not have the Equality Delivery System (EDS2) Framework.

ACTION: AW to indicate when the Prosecution Policy will be available.

23	**Update on the 61 recommendations from the Review of Governance Arrangements within Secondary Care (2022) by Professor Hugo Mascie-Taylor**	**Action**

AM advised the Board that this monthly report details the progress against each of the 61 recommendations in the Review of HCS Clinical Governance Arrangement within Secondary Care (2022).

Many of the recommendations are being addressed through the work detailed in the reports on today's agenda, including the establishment of this Board.

- As of August 2023, seven recommendations have been marked as complete.
- 11 are close to completion.
- 41 recommendations are in progress.
- Two have not started (due to dependencies).

A similar approach is being taken to this as in the MIP and any evidence to support closure of a recommendation is reviewed closely.

The detail regarding impact and outcomes of the recommendations are covered across a variety of agenda items. In response to HMT's question, AM advised that the recommendations are not embedded in BAU, rather the action plans, monitoring of progress, reporting and tracking are embedded. This will continue to be monitored through the Change Programme Board and Committees. AM suggested that if the Board would like to review any specific recommendations, this is presented as a separate paper, rather than in the overview document as presented today. CD responded it would be helpful to have a forward plan for fewer but more detailed reports which would facilitate deeper discussions i.e., understanding what is really important / urgent and as a Board, what difference can be made so that the people of Jersey experience this. ACTION: Quarterly report Update on the 61 recommendations from the Review of Governance Arrangements within Secondary Care (2022) by Professor Hugo Mascie-Taylor to be presented to the Board.	

24	**Mental Health and Capacity Legislation – Report from the Multi-Agency Assurance Group**	**Action**

AW advised that at the beginning of 2022, there was no mechanism for monitoring how the Mental Health law and Capacity Law is applied: the multiagency oversight group was established in response to this. Key points,

- Currently developing proposals with SPPP for changes in legislation as gaps have been identified. In addition, there are nuances that require redrafting.
- Documentation is being reviewed.
- Strengthening the information that is given to patients, so they are able to understand their rights when they are detained.
- The review process for those detained in the community on long-term leave has been strengthened.
- Implemented a process for the authorisation of designated professionals (those that have statutory roles) to ensure that these individuals are appropriately qualified, experienced and authorised.
- In the last 21 months, there have been two instances of unlawful detention. On both occasions this was due to the incorrect completion of documentation, and this was quickly corrected. Both individuals and their legal representative were notified of this.
- Quality of documentation is highlighted as a theme and whilst this does not result in unlawful detention, it can be improved - there is quality improvement work in relation to this.
- Working jointly with the Police around the use of Article 36 (Police ability to detain an individual as they believe there is mental illness and to hold them whilst an assessment is undertaken). There were 163 uses of this during 2021, and following partnership work, this has reduced to 112 during 2022 and to-date 49 uses. This does not mean that individuals are not being seen when in crisis, rather they are being assessed by MH services rather than the Police. The Police also report a 32% year-to-date reduction in amount of Police time associated with Mental Health cases.
- When Orchard House moves to Clinique Pinel, there will be a dedicated Article 36 suite. Currently, the Emergency Department is used.
- A Rapid Tranquilisation Policy has just been signed off and use of this will be monitored.
- The provision of training in Capacity and Self-determination has resulted in a significant increase in applications for a capacity assessment. There is currently a high number of individuals waiting for this assessment. Each application is reviewed and risk assessed. In addition, there is an improvement plan to reduce these waiting times.

ACTION: It was agreed that this report is presented to Board on a 6 monthly basis (March 2024).

25	**Management of Policy Documents and Procedural Guidelines**	**Action**
Paper taken as read. Key points,		

- This is an area where oversight has not been good, but an understanding of the current position has improved following the appointment of a Policy Manager as part of the Quality and Safety team.
- Work to address this includes further appointments to compliance roles and the implementation of a policy management system. However, it is unlikely that either of these will be in place until Q1 2024.
- There is a process for the oversight and governance of new policies developed. However, significant work is required to bring current policies up to date.

When addressing the issue of ratification, SMK explained that when developing policies, many individuals do not recognise the consequences for the wider organisation and there needs to be a process to identify these. However, the current PPRG mechanism could be improved. For clarity, the function of the PPRG is not to ratify already agreed evidence-based guidelines.

A general concern was expressed that the paper does not provide a sense of how big a problem this is. CS advised the Board that the Care Quality Commission (CQC) was used as a framework to determine what they would expect as a suite of policies for an organisation of the size of HCS. There is a level of confidence that HCS does have many of these.

In response to HMTs question about the level of confidence in being able to resolve this, PA explained he is confident that HCS is beginning to sort this out but asked the Board to acknowledge that this will take time. The gaps in HCS policy are not fully understood. Policy management is a feature of the newly established monthly quality governance reviews.

ACTION: A position statement to be presented in January 2024 regarding the suite of corporate policies that help to provide assurance that HCS is safe, well-led and effective.

26	Overdue Risks	Action
PA explained this paper was produced in response to an issue highlighted in a previous (shadow) board meeting regarding a high number of overdue risks. This paper demonstrated the number of overdue risks has significantly reduced.		

27	Statutory and Mandatory Training Needs Analysis	Action
AW explained that this work has been led by himself and JM, with a significant contribution from Tim Hill, Practice Development Sister HCS. There is no clearly identified set of mandatory training requirements for HCS staff. This paper describes how this will be achieved and sets out in detail the mandatory training HCS is intending to prescribe from 2024 onwards. AW emphasised that much of this training is being carried out already, however this provides a framework. CD commented on the absence of Equality, Diversity and Inclusion training and AW explained that this is covered in the GOJ mandatory training. Where HCS does not cover elements of training, these will continue to be delivered by GOJ. AW asked the Board to note that this is the first step and there will be training in specific clinical areas that will be required to be completed. On behalf of the Change Team, CS advised the Board that the importance of this policy cannot be underestimated and commended AW / JM for this work. The Board endorsed the Policy and an update to be provided in January 2024. ACTION: An update to be provided to the Board in January 2024.		

28	Consultant Appointments	Action

CB explained that due to the level of salary for Consultants, the States Employment Board (SEB) is required to approve all Consultant posts. 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 (following this signed by the Chief officer for HCS, Group Director PCS and the Minister for Health and Social Services).
4. By SEB

HMT confirmed that the purpose of the Board is to determine whether the funding is available, is it safe etc. before it goes to SEB.

AH asked if HCS was satisfied with the recruitment element and SG confirmed that HCS follows best practice in the UK with Royal College attendance.

In response to CD's question, CB responded that this process is required for all posts, not just new posts. Following this CD sought to clarify that this process has to be followed for posts in the current establishment that are required for operational delivery.

The Board approved the proposal that all proposed Consultant appointments should come to the Board prior to SEB with immediate effect.

29	**Estates Report**	**Action**

The paper which describes the current HCS estate was taken as read. The importance of having a decant ward is described to allow service continuity whilst carrying out ward refurbishments.

HMT asked JC to provide an update regarding Reinforced Autoclaved Aerated Concrete (RAAC). JC advised that an independent structural engineer has visited the Estates and three locations containing RAAC have been confirmed. Further investigation is required but there is no current concern regarding the need to decant these areas or stop services within these areas. The mitigation and management plans will follow the report.

The capital funding provided for the backlog maintenance programme is a rolling annual sum to support the BAU and capital management of the estate is now a key element of day-to-day business.

CD thanked JC for the report and advised it contains a compelling case for new facilities.

ACTION: It was agreed that NEDs would receive a separate briefing (workshop) on the Estates, including visits to all the sites.

	Questions from the Public	**Action**

No pre-submitted questions.

HMT asked the members of the public if they had any questions that arise from the agenda.

Member A

Q1. Waiting times

A1. Waiting times have been addressed through the agenda item 13. CB confirmed that the aim of HCS is to reduce waiting times which is very much dependent on having the right workforce and physical capacity to carry out the work. The £5million pound allocation will help to address the waiting times.

Q2. Has the Board considered the introduction of a whole-Island private health insurance programme. In addition, has a Pan-Island collaboration which could include France been considered? A2. HMT responded that the HCS Board is not responsible for how the Island funds healthcare. France has not been considered due to the language barrier and the Professional Regulators are based in the UK, not France. Work is continuing with Guernsey. Q3. Noting the financial overspend, will costs escalate as Jersey moves towards the proposed multi-site facilities. A3. The Board have not had the opportunity to discuss these issues and understandably been consulted. There will be a future Board workshop on this issue. In principle, duplication of sites has a risk of increasing costs and making safety a more difficult issue. Q4. What will the HCS Board be advising HCS and the Minister for Health and Social Services in methods not only to counteract the current spending but the measures to be put in place to contain future overspends. A4. Healthcare and social care costs will increase, and a political decision will be required in the future as to how this is funded. Health inflation runs across the world at approx. 8% / year which is well above normal inflation. A also commented on the costs of Managers increasing from 12 in 2012, to 131 managers in 2023 (describing these figures as accurate). CB advised the latter figure is incorrect as concluded by a recent review. A paper has been sent to the SEB and agreed by the SEB which shows that the number of managers in HCS is 1.7% of the total workforce, equating to approx. 20-30 frontline managers and 70 speciality managers. CB advised that HCS is undermanaged, especially when compared to similar healthcare organisations. **Member B** Q1. Does the Board feel it could recommend that the Care Quality Commission (CQC) is given legal status to undertake an inspection? HMT responded that his understanding was that the JCC were working closely with the CQC and that the methodologies might be similar. However, Jersey has chosen to establish its own independent commission and HCS looked forward to working constructively with it. Further discussions on the issue took place.	

	MEETING CLOSE	**Action**
Date of next meeting: Wednesday 1st November 2023		

Royal College of Physicians

Setting higher standards

Invited Reviews

Report of the invited service review to

Jersey General Hospital, Health and Community Service, Government of Jersey on 3 and 4 November 2022

1 Executive summary

1.1 Background and context

About Jersey

Jersey is the largest of the Channel Isles, located between England and France with a population of approximately 100,000 (including both residents and visitors) (Jersey, Statistics). Its governing structures are unique in that it is a self-governing parliamentary democracy under a constitutional monarchy[1] with its own financial, legal and judicial systems.

The healthcare services on the island are overseen by the Department for Health and Social Care and are not part of the National Health Service (NHS). Unlike the NHS, the service is not nationalised, and many treatments are not free at the point of use. Treatment within the accident and emergency department (A&E) is free, as well as prescriptions and some hospital treatments for residents. In Jersey, both residents and non-residents are required to pay for GP services.

Jersey General Hospital

Acute services

There is one hospital on the island - Jersey General Hospital based in St Helier, with approximately 219 beds and 14 wards (of which two are private wards).

The acute services at the hospital comprise of:

- an accident and emergency department (A&E) which has an ambulatory care area located at the back of the stroke ward (Corbierre ward)
- an acute assessment unit (AAU), a 25 bedded unit (20 acute admissions beds and five enhanced care area beds)
- an intensive care unit (ICU), a six bedded unit
- a same day emergency care (SDEC) area.

The AAU, ICU and base wards are not co-located to the A&E.

External links with other centres

The hospital has formal links with several UK centres for different services, for example, the Wessex Deanery of Health Education England supports the placement of medical students at Jersey General Hospital, and there are links with the University Hospital Southampton NHS Foundation Trust, to provide specialist care for neurosurgical patients.

Acute pathway at Jersey General Hospital

Most patients on Jersey that require acute medical care, enter the acute care pathway via the accident and emergency department (A&E), and are subsequently transferred to the acute assessment unit (AAU) for initial (first 24-48 hours) assessment, observation and clinical management. After which, the patient is

[1] Constitutional monarchy may refer to a system in which the monarch acts as a non-party political head of state under the constitution.

either transferred to a base ward (i.e. a non-acute ward) if in need of further inpatient care, or discharged home if medically stable. Some patients are transferred to the ICU if they require intensive treatment and closer monitoring. Once the patient's care has been optimised on the base ward, the patient is discharged home or to an out of hospital care facility.

Commissioning of the invited review

This invited review was commissioned by the Health and Community Services Department, Government of Jersey following concerns raised by staff and patients with respect to the acute care services at the Jersey General Hospital. Several concerns had been raised about the safety and quality of care provided to patients which had spanned the initial contact with the emergency department, through to the care received within the acute services, to the patient's transfer (to a base ward) and subsequent discharge. Issues raised by several serious incident reports had demonstrated: poor multi-professional team working and communication across the acute medicine service and other specialties, poor communication with patients and their family, and an informal approach to evidence-based medicine.

A combined clinical record and service review

The review was chaired by the deputy medical director for invited reviews, a consultant respiratory physician, and the review was undertaken by five other specialist reviewers. The review team included two acute medicine consultants, one stroke consultant, one further respiratory consultant and one cardiologist, reflecting the most common conditions seen by an acute medicine service. Steps were taken to ensure that, as far as possible, the review team's experience was reflective of the setting being reviewed, for example, other than the chair, all the consultant specialist reviewers worked in rural or remote settings.

The review comprised three key elements:

- Structured judgement review of 16 clinical case records, which were a mix of index and control cases (for details see section 6.1 Terms of reference 1 – clinical record review).
- Documentation review comprising evaluation of organisational level Information including service specific information, clinical governance documentation, walkaround of the A&E, AAU and medical wards (for details see section 8. Appendix 1: documents received and reviewed).
- Interviews with staff (for details see section 8. Appendix 2. Interviews and visits to clinical areas).

The findings from the structured judgement review and the interviews can be found at section 6. The conclusions of the review team specific to each of the terms of reference can be found at section 2.

1.2 Summary of findings

The patient journey, from the initial contact with the medical team in the emergency department, through to the AAU, within the first 24 hours, was generally of a good standard. In most cases, the patients received the appropriate initial assessment, investigations and timely treatment.

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.' Most of these patients received care either on the AAU only, or on the AAU and base ward.

The key themes identified within the clinical record review which contributed to the 'poor care' grading post 24-72 hours of care (within the AAU and base wards) were:

- an extended length of stay on the AAU for patients in need of transfer to a base ward.

- an extended length of stay on the base wards for patients medically optimised for discharge (MOFD), of note, some patients were inappropriately discharged (too early) (see section 6.1.3. Initial assessment and management (first 24 hours of care)).
- a lack of systematic ongoing review and refinement of the patient's diagnosis and management strategy following initial decision making within the AAU and base ward which possibly affected the patient's clinical outcome (see section 6.1.3 Clinical decision making).
- changes to the patients' clinical parameters (i.e. sodium levels, blood pressure etc) that were not always acted upon and, if so, they were not actioned within a timely fashion (see section 6.1.3 clinical decision making).
- Whilst in most cases, the review team considered the approach to prescribing as 'adequate,' there were examples of 'poor care' where prescribing was considered by the review team to be out of standard practice, for example, those specific cases where prescribing lacked an evidence base, or lacked a thorough clinical investigation or diagnosis to support the treatment strategy (see section 6.1.3 clinical decision making).

Overview of findings from the AAU

Following the review of case records, and interviews with staff, the overriding conclusion of the review team, was that the acute assessment unit (AAU) was no longer functioning as one unit, and instead functioned as three separate units:

1) an assessment area
2) a higher dependency area
3) a base ward.

In attempting to deliver these three disparate functions impacted negatively upon patient care, particularly after 48 -72 hours following admission. The review team identified that the AAU had a lack of identity thereby reducing the effectiveness of the AAU to function and was not conducive to optimising patient care. Medical leadership of the unit was limited, although the team were assured that one of the new appointments had a leadership role embedded in their job plan.

Often it was difficult to identify a named consultant responsible for patient care both on the AAU and on the base wards, which is an essential component of good clinical management and ensuring optimum communication with patients and relatives.

Patient transfer from the AAU to base wards appeared to be prompted by bed availability rather than related to appropriate base ward subspecialisation which will, likely, have an overall impact on quality of care, length of stay and staff recruitment and retention.

Some aspects of prescribing were also raised as potential patient safety concerns with respect to the electronic reporting systems within the AAU (as described in section 6.2.2 Protocols and pathways). At the time of the review, the mix of electronic and paper prescribing systems across the acute services may impact on patient safety, namely timely administering of medication. This should be acted on immediately when also considering the number of locum staff and short-term staff moves between clinical areas (see recommendation H, section 3 recommendations).

The review team's core recommendations were:

- for a redesign of the AAU, with a move to reducing the number of beds, so that the unit can appropriately function as an acute assessment unit to promptly initiate medical treatment and facilitate discharge or transfer of patients to a base ward within 48 hours. This will require robust

clinical leadership both at AAU and executive team levels. In doing so the service should follow the *joint Society for Acute Medicine (SAM) and the Intensive Care Society's Guidance on development and implementation within acute medicine*[2] and the *RCP Acute care toolkits*[3] which puts quality and patient safety at the heart of the service

- a robust system for having a named consultant responsible for the patient within the AAU and on the base wards
- robust and appropriate arrangements for the transfer of patients to the most appropriate base ward according to patient needs, as these are key elements required to improve patient care and facilitate the efficient flow of patients through the service
- the implementation of a unified prescribing system.

Overview of the base wards

Due to the small population on Jersey, most inpatients would be considered as falling under the care of "General Medicine". The base wards operate a "ward based" system whereby all patients on a specified ward, whatever their underlying admission problem, are managed by the clinical team (Consultants and non consultant doctors) assigned to that ward. Despite this, most consultants identified themselves as specialists and several appeared to have limited (or none for cardiology) inpatient ward responsibilities scheduled into their weekly activity. At the time of this review, several specialist consultants were aiming to reduce further their inpatient ward care to focus primarily on specialty work only (for example undertaking medical procedures, such as endoscopy for gastroenterology).

The review team identified that, at times, it was difficult to identify who the managing consultant was for the patient, there were limited consultant ward rounds and patient care appeared to "drift" with limited subsequent review and refinement of the initial patient diagnosis and management plan.

The review team viewed that the tension between the nature of the predominantly "general medicine" inpatient cohort and the desire of several of the consultants to increase their sub-specialist interests had potentially contributed to a lack of ownership and responsibility for the ongoing management of acute general medical patients transferred from the AAU to the base wards.

Since the COVID-19 pandemic, the base wards had lost their previous identity of having some sub-specialty identity e.g. general medicine with gastroenterology and general medicine with respiratory medicine (i.e. Bartlett and Rozel wards respectively).

There was evidence of excellent current practice within Corbierre ward (a general medicine ward with a stroke and neurology subspecialty interest). The review team considered the ward exemplary and, which at the time of this review, was led by a recently appointed consultant in general medicine with a sub-specialist interest in stroke. The ward arrangements involved regular ward rounds supported by the consultant, formal multidisciplinary team meetings (MDTs), a named consultant to support the inpatients, and new referrals from the AAU. However, this was, in large part, due to the practice of the individual consultant and is unlikely to be sustainable, as a single-handed practitioner, in the medium to long term.

The review team were repeatedly informed that there remains a large cohort of patients medically optimised for discharge (MOFD), a situation which appears to be compounded by the private funding arrangement of social care in Jersey resulting in sub optimal bed usage, excessive length of stays and exit block for A&E, AAU and the base wards.

[2] https://ics.ac.uk/resource/enhanced-care-guidance-am.html
[3] https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-4-delivering-12-hour-7-day-consultant-presence-acute-medical-unit

The review teams core recommendations were:

- The executive team to ensure there are an appropriate number of general medicine consultants with a sub-specialist interest to support the ownership and oversight of the inpatients transferred from the AAU and managed on the base wards and that these consultants are job planned to deliver regular multi-professional board rounds and ward rounds
- That Corbierre ward should be used as a benchmark model to support the development of other base wards (i.e Barlett and Rozel both general medicine wards, without a subspecialty).
- A review of the discharge processes and strategy for dealing with patients who are MOFD.

The full recommendations arising from this review are found at section 3.

2 Overall conclusions

2.1.1 Structure and function of the acute assessment unit (AAU)

- Overall, the review team concluded that at the time of this review, the AAU structure and function was not best supporting the flow of patients from the ED to the base wards, or for discharge.
- The review team were of the opinion that the managerial leadership team should reconsider the size of the AAU to ensure that the unit reflects the current activity and that any change to the AAU is supported by direct communication and liaison with medical and non-medical staff (see recommendation D, section 3 recommendations).
- The review team would encourage the managerial leadership to refer to the recently published Society for Acute Medicine, guidance on development and implementation within acute medicine (November 2022), to facilitate changes to improve the AAU and the enhanced care areas[4].

At the start of the COVID-19 pandemic, the AAU was expanded from a 16 bedded unit to a 25 bedded unit and the decision was also made to introduce a higher-level care area within this staffed by the AAU team. Whilst at the height of the COVID-19 pandemic, the expansion of the unit may have supported the acute pathway for patients, the review team were of the view that the evolution of this did not best support the contemporary care of patients.

At the time of this review, the review team were of the opinion that the AAU was functioning as an assessment area, higher dependency area and a base ward, and they agreed with some staff concerns relating to inadequate staffing numbers, prolonged stay of patients on the AAU as a result of the delayed transfer of care (DTOC) to base wards and delayed discharge of medically optimised for discharge patients (MOFD) (see section 6.2.2 protocols and pathways).

The review team thought, that given the activity and population size, an optimal AAU size would be 15-18 beds, rather than the current 25 bedded unit. They also considered the optimum size of the enhanced care unit (ECU) to be three beds rather than six (see recommendation D, section 3 recommendations).

The review team concluded that the number of beds within the AAU (25 beds at the time of this review) was not best supporting the acute activity for Jersey General Hospital and that a decrease in the number of beds would ensure that acute patients are transferred to the relevant base ward without a prolonged stay on the AAU.

The review team were also of the opinion that the reduction in size of the AAU could also potentially allow the same day emergency care area/ambulatory care to be co-located thereby enabling increased flexible movement of patients and staff between these areas according to clinical need.

The overall rationale for this recommendation would be to support an effective and streamlined patient pathway from the emergency department, through to the AAU, base ward and discharge.

[4] https://www.acutemedicine.org.uk/download/enhanced-care-guidance-nov-22

2.1.2 The initial management of patients within the emergency department and acute assessment unit

- Of the 16 cases reviewed as part of the clinical record review, the review team concluded that within the first 24 hours of care (in the ED and AAU), the majority of patients received prompt and timely care, appropriate history taking, relevant investigations and the timely diagnosis and treatment of the patient's condition.
- Key themes for improvement were focused mostly on the care received within the AAU (after 24-72 hours of care) and for some patients transferred from the AAU to the base wards with respect to their subsequent, ongoing care.

During the interviews with staff, the review team were informed about the mechanisms in place to discuss management plans with patients, and clinical decision-making processes with colleagues on the AAU. They were of the view that the newly introduced AAU team huddle, daily post take ward round, a consultant present from 8am-8pm (weekdays), and a rolling review of new patients rather than fixed ward rounds were all considered good practice (see section 6.2.3 multi-professional meetings – AAU).

Less clear to the review team, was the consultant rota to support AAU patients and junior staff 8pm-8am and on weekends and the operational delivery of this, which the review team heard was variable and individual dependent (see section 6.2.3 multi-professional meetings - AAU). The review team concluded that greater consultant presence over the weekend was needed, not only for continuity of care, but also to support the appropriate escalation processes and transfers of care (see recommendation F, section 3 recommendations).

Many of the clinical cases reviewed as part of TOR 1, evidenced appropriate history taking by the medical team. However, the review team did identify variation in the medical clerking process where some cases were missing key information to inform management plans and accurate diagnoses. The review team acknowledged that although this had occurred in a select number of cases, they were of the opinion that refinements to the medical clerking process was needed (see section 6.1.2, initial assessment – medical clerking). To encourage consistency in clerking across the unit, the review team suggested the development of a standardised proforma for clerking (see recommendation C, section 3 recommendations).

2.1.3 Ongoing care of the patient (after 24 hours of care)

- Of the 16 cases reviewed as part of the clinical record review, the patient's ongoing care (i.e. after 24-72 hours) was considered by the review team as 'less than good care' in most cases. In support of this judgement, the review team thought that the clinical oversight by the managing clinician and having a named consultant responsible for the patient's care was often lacking.

In most cases, the review team found it challenging to identify the main clinician responsible for overseeing the care of the patient in the AAU and also on the base ward. The review team were informed that some consultants with a sub-specialist interest had recently limited their inpatient workload activity and some had no inpatient activity scheduled in their workload at all (see section 6.2.5 workload).

The review team concluded that following 24-72 hours, the patient journey through the acute pathway could be better supported by consultant ownership of the patient and this may involve the consideration of no further consultants with a subspecialty interest being allowed to come off the ward and that inpatient activity should remain within the consultants' job plans (see recommendation I, section 3 recommendations).

The review team observed that there appeared to be a lack of regular general medicine consultant ward rounds/consultations for some of the patient cases that were reviewed (see section 6.1.3 clinical record review - clinical decision making). The review team described the flow of patients (after 24 hours of care) to clinically "drift" through the acute medicine pathway, in part due to those themes described. They were of the opinion that there should always be a named consultant, for the review of the diagnosis, investigations, management plans and active discharge planning including estimated date of discharge (EDD) of all of their patients (see recommendation I, section 3 recommendations).

The review team found, at times, that despite clinical parameters being documented within the notes, there was limited action to address the deleterious[5] changes displayed by the patients and often a lack of test results being acknowledged (or actioned) by the medical team (see section 6.1.3 clinical record review - clinical decision making). The review team acknowledged that the organisation had undertaken a recent quality and risk task and finish project to improve the serious incidents related to the deteriorating patient (see section 6.4.2 governance documentation review). The review team welcomed this initiative and were of the opinion that good practice would involve regular monitoring of the outcomes following implementation of the quality improvement project (see recommendation R, section 3 recommendations).

2.1.4 Medically optimised for discharge patients

As described above, the review team were informed that there were too many delayed transfer of care (DTOC) and medically optimised for discharge (MOFD) patients across the AAU and base wards. Interestingly, this finding was not echoed within the clinical record review where two cases experienced a rushed discharge and were subsequently readmitted on the same day, or shortly afterwards (see section 6.1.3 clinical record review – clinical decision making). What was clear to the review team was the variation in discharge processes across the AAU and base wards (see section 6.2.2 protocols and pathways – discharge arrangements). It was heard that further support was needed from the consultant body and discharge nurses to appropriately manage the timely discharge arrangements for patients and the review team would agree with this suggestion (see recommendation G, section 3 recommendations).

2.1.5 Approach to prescribing

- Whilst in most cases, the review team considered the approach to prescribing as 'adequate', there were examples of 'poor care' where prescribing of certain medication was considered by the review team to be out of standard practice (i.e. lacking an evidence base), or lacking a definitive clinical investigation and diagnosis to support the treatment (see section 6.1.3 clinical decision making).
- The review team identified patient safety concerns during the service review visit to Jersey General Hospital, which concerned the mixed economy of electronic and paper prescribing.

Considering the lack of evidence base for prescribing, one case, RCP 12 was of particular concern and graded by the review team as 'unsatisfactory'. The review team's judgement of this case was underpinned by their belief that the diagnosis of epilepsy was unsecure (see section 6.1.1 overall rating for quality of care for further details). The review team concluded that patients should be prescribed with the most up-to date, evidence-based treatments, the clinical leads should support and acknowledge the updates to recent NICE guidelines and embed this into every day clinical practice, where not doing so already.

The review team were informed by nursing staff of two varying prescribing systems in place across the emergency department (ED) and the AAU. Paper prescribing was utilised within the ED and intensive

[5] Changes that may cause harm to the patient.

therapy unit (ITU), whilst an electronic prescribing and medicine administration (EPMA) system was used within AAU. The safety concerns arose as the review team learned that when covering staffing gaps some nurses may not have access to the EPMA system which often results in delays to accessing medication for patients (see section 6.2.2 protocols and pathways – prescribing).

The review team concluded, that to avoid any potential patient safety concerns, the relevant ED/ ITU nurses should access the EPMA system so that medications can be administered to patients on the AAU without delay. They were of the view that there is an there is an immediate need to ensure that ED and ITU are updated to the EPMA system (see recommendation H, section 3 recommendations).

2.1.6 Referral to tertiary care and the involvement of specialist teams

The review team were provided with examples of strong but informal links to tertiary centres for example, Oxford Health NHS Trust for cardiology, Kings College Hospital NHS Foundation Trust for hepatology and University Hospital Southampton NHS Foundation Trust for stroke medicine. Many staff reported on the benefits of these links with tertiary centres, particularly regarding MDT meetings for the discussion of complex cases and the opportunity for a second opinion. These links seem to have been built upon historical, individual personal links between a named Jersey clinician and a specialist centre (see section 6.2.3 multi-professional meetings). The review team were not provided with the service level agreements for these arrangements and some of the clinical pathways provided did not appear to clearly detail the criteria for transfer of care in the standard operating procedure (SOPs) (see section 6.2.3 multi professional meetings).

Furthermore, there were several examples within the clinical record review, and, supported by comments by medical staff during interviews, which highlighted examples of clinical teams at Jersey General Hospital not following the advice provided by the relevant specialist teams at the tertiary centre and the rationale for this deviation from recommended treatment pathways was often unclear (see section 6.1.5 evidence of communication with colleagues). The review team concluded that in most of these cases, good practice would have been to follow the advice provided by the specialist teams at the tertiary centre, and if the advice was not followed, to document clearly a clinical justification for this in the records (see recommendation J, section 3 recommendations).

2.1.7 Multi-professional team meetings and team working

AAU: multi-professional meetings
The review team concluded that within the AAU, multi-professional team meetings were generally of an adequate standing having recently been improved by the implementation of a newly introduced team huddle and daily morning post take ward round (see section 6.2.3 multi-professional team meetings - AAU). Despite this, many patients had a prolonged stay on the AAU.

AAU: team working
The review team were of the opinion that better communication between medical, nursing, AHP and bed management staff on the AAU and base wards could potentially support and improve the appropriate and timely transfer of AAU patients onto the base ward (see recommendation E, section 3 recommendations).

Base wards: multi-professional meetings
Overall, the review team concluded that there was wide variation in the process for both multi-professional meetings (eg board rounds) and more formal MDT meetings from review of the clinical cases and also discussions with staff at the interviews (see section 6.2.3 multi-professional meetings – base wards).

The review team observed variation across teams as to what constituted MDT meetings ranging from some staff describing an informal discussion between consultant colleagues, to, other teams, such as cardiology having a formalised MDT meeting involving specialist nurses, and also linking into the MDT meeting at Oxford. The review team considered the cardiology MDT meetings as exemplary practice. It was also noted to the review team that stroke MDT meetings are also in the process of being formalised with input from allied health professionals (see section 6.2.3 MDT meetings).

The review team concluded that the purpose and function of MDT meetings are paramount to ensuring effective and safe patient care, and that all teams should follow a formalised multi-professional and MDT working structure with dedicated time allocated for those relevant patients to be discussed, based on patient need (see recommendation J, section 3 recommendations).

Base wards: team working
Unfortunately, MDT meeting examples provided by cardiology and stroke, were not reflective of the MDT meeting processes across the service. Many of the allied healthcare professionals felt as though they were not considered for their input into MDT meetings, or, were not allocated enough time to participate and, in some cases, they perceived that they were actively excluded (see section 6.3.3 MDT working).

The review team were of the opinion that cross-specialty working required improvement. One main area of concern, as raised by several staff during the interviews, was the interaction between all medical teams and the radiology department (see section 6.3.3 multi-professional team working), in particular around access to timely imaging. Concerns were raised by several staff regarding the behaviour of some colleagues within the radiology department which they viewed as obstructive. It may be there are challenges and blocks that the radiology team experience, such as resourcing. What is important now, is that the relevant staff reflect on the issues highlighted and work together constructively to address these. The review team would recommend that all staff members are reminded of the GMC code of conduct [6](see recommendation N, section 3 recommendations).

2.1.8 Staffing

The review team were aware that there have been ongoing difficulties recruiting and retaining staff (all healthcare workers) to posts in Jersey due to the high cost of living especially related to housing costs (both rental and purchase).

AAU staffing
The review team identified concerns about the nurse staffing ratio of the enhanced care area (ECA) which was considered as sub-optimal for an area designated as an higher-level care area (see section 6.3.2 staffing). The review team advised the clinical leadership team to refer to the enhanced care guidance on service development in the hospital setting (November 2022)[7] which includes safe staffing numbers. (see section 3 recommendations).

Base ward staffing
The review team heard that medical, nursing and AHP staffing was often reduced on the base wards with other staff being moved at short notice to try to cover gaps and regular use of bank and agency staff (see

[6] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-3---communication-partnership-and-teamwork#working-collaboratively-with-colleagues
[7] The previous May 2020 edition was recommended within the initial feedback letter, but since then a more recent version has been published (November 2022)

section 6.3.2 staffing). This was considered by the review team as an unsustainable model for safe and efficient care.

Recruitment and retention

The review team were encouraged to hear that there had been a successful, recent (at time of review) recruitment drive for increased medical consultant posts (see section 6.3.2 staffing). The review team were informed that some nursing staff had requested to be seconded for various career development purposes, but this was not always allowed by leadership, resulting in resignations of permanent highly skilled staff resigning and returning on the bank (see recommendation P, section 3 recommendations).

Further to this, the intrinsic high cost of housing remains and the organisation may have to consider medium and long term strategies to retain staff, particularly nurses and AHPs (see recommendation Q, section 3 recommendations).

Locums

As previously described, the review team were informed that several medical consultants no longer had inpatient activity scheduled as part of their job plan. As a result, there were more staff grade doctors doing ward rounds and junior grades due to a possible lack of senior consultant input. The review team heard that many of the non-consultant grade medical posts were filled with locums, with a high turnover of staff. Locum non-consultant grade staff were utilised to care for those inpatients instead (see section 6.3.2 staffing). However, the review team raised concerns about this approach particularly with respect to continuity of care (see recommendation F, section 3 recommendations).

Further to this, the review team would advise that job plans are created for all consultant staff based on patient need, fairness and agreed "tariffs" for work delivered e.g. ward rounds, board rounds, outpatient clinics, on call, procedures (see recommendation M, section 3 recommendations).

Clinical leadership

At the time of this review, the clinical leadership post within the acute medicine services was out for advertisement, and a clinical nurse specialist was in post in the interim (see section 6.3.2 quality of staffing).

2.1.9 Governance

The review team acknowledged the investment and additional resource recruited to support the new governance arrangements at the healthcare organisation. The review team were of the opinion that the new appointments had demonstrated progress towards providing a robust framework for facilitating governance meetings, however, they were also of the view that further work is needed. They found that there was limited detail inputted into the minutes regarding the serious incidents (SI) and a lack of timelines associated with ratifying new protocols/guidelines and SI reports and updating old SOPs/guidelines (see section 6.4.2 quality of clinical governance arrangements). The review team identified limited evidence of trackers to the outcomes of the SI panel meetings and a lack of timelines produced for the quality improvement (QI) projects that were being carried out. There was also no clarity in how the service registered their audits and QI projects. Further work to ensure timeliness in completing governance projects such as these is needed (see recommendation R, section 3 recommendations).

The review team found that there was an absence of forums to discuss serious incidents within the acute services and that a standardised morbidity and mortality meeting was not apparent (see section 6.4.2 quality of clinical governance arrangements). There was no evidence of governance meetings/process

within the medical care group/specialties where their performance was being monitored/assessed (i.e endoscopy numbers/complication within JAG standards) and complaints etc. The review team concluded that active learning from such cases is vital in understanding and embedding improvements to patient care across all members of the team within the service (see recommendation S, section 3 recommendations).

3 Recommendations

Key for timelines for implementing recommendations:

> **Immediate (0-3 months)** – action should be completed within 3 months of receipt of the initial invited review feedback letter.

> **Short term (0-6 months)** – action should be completed within 6 months of receipt of the invited review report.

> **Medium term (6-12 months)** – action should be completed within 12 months of receipt of the invited review report. Planning for actions resulting from these recommendations should start as soon as possible.

> **Long term (12-24 months)** – action should be completed within 24 months receipt of the invited review report. Planning for actions resulting from these recommendations should start as soon as possible.

Recommendations

No.	Executive team	Timelines	Related ToR(s)
A.	This report should be considered by the executive team or relevant subcommittee and oversight of an action plan should be provided to a Non-Executive Board member to ensure these recommendations are completed.	**Immediate (0-3 months)**	1-4

No.	Clinical record review	Timelines	Related ToR(s)
B.	The Medical Care Group should review the findings from the clinical record review (CRR) and ensure that any key learning points are fed back to the AAU teams at the governance meeting to embed learning within the workforce.	**Short term (0-6 months)**	1
C.	To ensure consistency of clerking patients, the AAU clinical lead should, in collaboration with junior staff, develop a formalised, consistent and robust approach to medical clerking. The department should consider: • developing a standardised medical clerking proforma. • the medical clerking proforma should be ratified at the appropriate clinical governance meeting.	**Short term (0-6 months)**	1

No.	Protocols and pathways	Timelines	Related ToR(s)
D.	The healthcare organisation should work with the acute medicine clinical teams to review the structure, function and size of the AAU. Consideration should be given to: • the number of beds with respect to the AAU activity, population size and staffing, see ref: Six to help fix document, NHS, GIRFT and iUEC (Models of Care (acutemedicine.org.uk)) • the number of beds in the ECU • location of the same day emergency care area (SDEC)/ambulatory care and whether the reduced number of beds allows for the co-location of AAU and SDEC • Consulting with medic and non-medic staff to input into the development of this restructure • The use of standard updated nomenclature for these areas e.g. Acute Medical Unit (in place of AAU) and SDEC for ambulatory care.	Medium term (6-12 months)	2
E.	The interaction between the base wards and the AAU to support patient care required improvement. The healthcare organisation should consider a review of the base wards taking into account the following: • the number of base ward beds and their location • the re-initiation of each ward having a subspecialty interest (in addition to delivering core general medical care) to give an identity and increased skill set for each of the wards akin to Corbierre ward. This recommendation should be carried out in collaboration with the clinical teams.	Medium term (6-12 months)	2
F.	At the time of this review, the weekend cover for patients relied mostly on junior staff. The healthcare organisation should support the review of out of hours working regarding consultant delivered care on the AAU at weekends with the aim that all patients across the AAU and base wards should be in receipt of a consultant review daily seven days a week.	Medium term (6-12 months)	2
G.	The service should consider appointing a discharge nurse to lead on supporting the appropriate discharge arrangements for acute patients.	Medium term (6-12 months)	2
H.	The executive team should support the department to make electronic prescribing systems available across the organisation, this is to ensure that all staff can access the system and access appropriate medication for their patients for whichever unit they are staffing at the time.	**Immediate (0-3 months)**	2
I.	To avoid the continued clinical drift of patients, the service leads should ensure that: • all patients have a named consultant which is visible to all staff, to the patient and the relatives • the named consultant is responsible, with their team, for the review of the diagnosis, review of investigations, review of	**Short term (0-6 months)**	2

	the management plan and active discharge planning including estimated date of discharge (EDD) of all of their patient • review of care occurs at multi-professional board rounds and regular consultant delivered ward rounds • consideration should be given to no further specialties being allowed to come off the ward in block.		

No.	Staffing and team working	Timelines	Related ToR(s)
J.	MDT working and MDT meetings including maintaining sub-specialist skills • Attending MDT meeting should be job planned for consultants • Appropriate AHP and nursing expertise invited to attend MDT meetings • Clinicians should be encouraged (mandated) to become a part of an MDT via another centre for their subspecialist areas of interest to ensure ongoing learning, maintenance of sub-specialist skills and review of more complex patients.	**Short term (0-6 months)**	1
K.	The healthcare organisation should ensure that all consultants have an up-to-date job plan which details their clinical commitments, in addition to other activities. The job plan should specify the standards expected for ward care.	**Medium term (6-12 months)**	1
L.	Services with a subspecialty interest eg gastroenterology, respiratory, neurology/stroke, diabetes and endocrinology, geriatrics should consider spending time each year in a specialist centre in the mainland or have visiting specialist attend their specialty services – outpatient clinics/procedures at least annually so that the organisation can be assured that the service remains current and optimum.	**Medium term (6-12 months)**	2
M.	The tariffs for delivering ward care should be agreed by the medical care group, consideration should be given to the following: • the specification should include multi-professional board rounds, face to face patient reviews and time for meeting relatives in addition to reviewing all patients regularly throughout the week • the tariffs for AAU should be the same between AAU consultants • the tariffs for the base ward should be pro rata for patient numbers for the general physicians.	**Medium term (6-12 months)**	2
N.	The healthcare organisation should consider an evaluation of radiology working practice, to identify and work through the 'blockers' when staff request imaging. All staff should be reminded of the GMC good medical practice domain 3: communication partnership and teamwork and together work on finding constructive ways to address these matters. See link:	**Medium term (6-12 months)**	3

	https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-3---communication-partnership-and-teamwork#working-collaboratively-with-colleagues		
O.	The clinical fellow rotas and induction required updating. The healthcare organisation should ensure that the clinical fellow grades have: • an induction commensurate to the proposed length of time that they are expected to stay which should include a named clinical/educational supervisor. • a rota populated and circulated at least 6 weeks in advance.	**Short term (0-6 months)**	3
P.	The executive team should review their processes for personal and professional development to allow for upskilling staff and staff retention and satisfaction.	**Short term (0-6 months)**	3
Q.	The executive team, should review on an ongoing basis, with the Jersey Government, the prohibitive cost of housing (rental and purchase) in Jersey which deters many healthcare workers from staying. Consideration could be given to incentivise housing support.	**Long term (12-24 months)**	3

No.	Governance	Timelines	Related ToR(s)
R.	The review team acknowledged the new appointments made by the executive team to support governance arrangements within the service. However, there should be continued work on the quality and safety structures. The healthcare organisation should ensure that: • teams are educated on the processes in place regarding governance • there is timely implementation of QI projects, and, guideline and SOP updates.	**Short term (0-6 months)**	4
S.	The Medicine Group should have a robust morbidity and mortality (M&M) process, the healthcare organisation should consider: • an M&M Standard Operating Policy including the definition of criteria for cases to be discussed, using a formalised tool or similar, • scheduled meetings, open to all (with time allocated to allow attendance) • agreed outcomes with timelines to improve care • subspecialty services should collect and measure audit data at formal audit/QI meetings to ensure quality outcomes and to guide QI.	**Short term (0-6 months)**	4