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Public Accounts Committee

Public Hearing

Witness: Director General of Health and Community Services

Monday, 21st October 2019

Panel:

Senator S.C. Ferguson (Chair)

Connétable J. Le Bailly of St. Mary (Vice Chair)

Deputy I. Gardiner of St. Helier

Deputy R.E. Huelin of St. Peter

Mr. A. Lane

Mr. T. Rogers

In attendance:

Ms. K. McConnell, Comptroller and Auditor General

Witnesses:

Ms. C. Landon, Director General of Health and Community Services

Mr. S. Nair, Finance Director

Ms. R. Naylor, Chief Nurse

[14:03]

Senator S.C. Ferguson (Chair):

Good afternoon. Welcome to this public hearing of the Public Accounts Committee. Now, I think you have probably met the warning document. No? Have we put the warning document out? Sorry about that. We are so used to people saying: "Oh, I have read it all before." If you have seen it before it has not changed. It is just making sure that everybody has seen it. Now, for the purposes

of the ladies … sorry, they are not all ladies, the transcribers in New Zealand, I am the Chair of the Public Accounts Committee, Sarah Ferguson.

Connétable J. Le Bailly of St. Mary (Vice Chair):

John Le Bailly, Constable of St. Mary and Vice Chair.

Comptroller and Auditor General:

Karen McConnell, Comptroller and Auditor General.

Mr. A. Lane:

Adrian Lane, independent member of the Public Accounts Committee.

Deputy I. Gardiner of St. Helier:

Deputy Ina Gardiner of St. Helier, member of the Public Accounts Committee.

Mr. T. Rogers:

Tim Rogers, also an independent member of the Public Accounts Committee.

Public Accounts Committee Officer:

Caro Tomlinson, P.A.C. (Public Accounts Committee) officer.

Assistant Scrutiny Officer:

I am Lindsay Power, assistant scrutiny officer.

Finance Director:

Steven Nair. I work in finance in H.C.S. (Health and Community Services).

Director General of Health and Community Services:

Caroline Landon, Director General, H.C.S.

Chief Nurse:

I am Rose Naylor, Chief Nurse, H.C.S.

Senator S.C. Ferguson:

Super. Welcome to the hearing. Now, in September 2018 the C. and A.G. (Comptroller and Auditor General) published a report on governance arrangements for health and social care, and in April 2019 she published a follow-up report on community and social services for adults and older adults. Both reports identified serious shortcomings in the delivery of health services to the public. The

department accepted all the recommendations and set out a plan to improve the problems identified. The purpose of this hearing is to understand from the Director General what progress has been made. We will ask some general questions first and then move on to more specific questions. So, how does the lack of progress on the new hospital impact on continued and uninterrupted services to the public?

Director General of Health and Community Services:

So, I do not think that the lack of a new build does impact upon the delivery of care because it is not about the building, it is about the care that is delivered within the building. I am confident that we are continuing to deliver that for the people of Jersey. Whether it is the right model of care is something that I have already discussed in a previous Scrutiny Panel, but I am confident that there is no negative impact upon delivery of service or, indeed, on patient outcomes.

Senator S.C. Ferguson:

Super, thank you. Adrian?

Mr. A. Lane:

We are interested in the connection between H.C.S. and Government at a corporate level. I wonder if you can just outline for us the initiatives being run at a Government level and how they are impacting on H.C.S.

Director General of Health and Community Services:

So we are working very closely with colleagues in S.P.P.P. (Strategic Policy, Performance and Population), which is our strategy and cannot remember all the Ps, prevention, policy and some other P, sorry. We are working very closely with them around some strategic developments around our wellbeing policy, around drugs and alcohol. We are also having conversations with them about public health and how that department sits and where it sits and what is the resource that is allocated to that. There have been some suggestions that public health would reside within H.C.S., which we do not think is the right place for it because we are not public health experts. We think that message needs to sit centrally within Government, but we are working closely with colleagues around that. We are also working with colleagues around some of the initiatives that are taking place around Sports Jersey, Get Active, around the work that is being done in C.Y.P.E.S. (Children, Young People, Education and Skills) around early education and early health. So we are involved in significant work streams across Government. We also are working on 2 joint governance boards around C.A.M.H.S. (Child and Adolescent Mental Health Services) and around the Ambulance Service, which have transferred from H.C.S. over the last I think it is 12 months. I think the Ambulance Service happened at the end of last year.

Mr. A. Lane:
C.A.M.H.S.?

Director General of Health and Community Services:
Sorry, Child and Adolescent Mental Health Services.

Mr. A. Lane:
Are there any areas where Government's initiatives are impacting on the way you run your business?

Director General of Health and Community Services:
I cannot think of any that are impacting significantly, but if I can ask colleagues, if I can ask my Chief Nurse if …?

Chief Nurse:
Not that comes to mind particularly.

Mr. A. Lane:
I am thinking of areas like Team Jersey or My Conversation My Goals, any of the corporate-level activity that is happening.

Director General of Health and Community Services:
Yes, absolutely. So Team Jersey, H.C.S. are very much part of that. We are the biggest part of Government as a service so we as exec directors are very much engaged around that and encouraging our staff to attend. We have rolled out the one conversation around our goals. We have a long way to go. It is not widespread across the organisation because we are so big. It takes a while really for us to get processes in place. Of course, we have the engagement around the Government Plan, which we have worked across departments to identify cross-Government schemes that can impact positively on delivery of healthcare for Jersey, particularly again, without wanting to repeat myself, around prevention.

Mr. A. Lane:
When would you expect to land your conversation, your goals?

Director General of Health and Community Services:
I would think that we would have that landed probably by the end of the first quarter of next year, to have it significantly landed in that it is being utilised properly in order to be able to deliver. We are doing it but for it to be really meaningful I would say the first quarter of next year.

Finance Director:

These things take time to embed, do they not? So we are doing the conversations. It is getting everybody to understand what it is all about and to make best use of it.

Director General of Health and Community Services:

As the C. and A.G. has identified, we have not been the greatest around adherence to process in the past in H.C.S., so a new process does require embedding. But what we are trying to do is we are trying to tie it up with all the work that we are doing around the T.O.M. (target operating model), the Jersey Care model, our big work plans within H.C.S.

Group Director, Operations and Transport, Growth, Housing and Environment:

Okay. It may be specific to Mr. Nair then: what about the changes to financial directions that are going to come through?

Finance Director:

We think those are a good initiative. We are working very closely with Kevin Hemmings and Richard Bell on there. We are heavily engaged in that. I have a session with Kevin Hemmings next week. Anything we can do to improve financial standards we are very keen to do. Health, by way of example, has already designed a financial modelling standard that is going to be applied across Government, so we are contributing in, we are not just receiving things from colleagues in the centre. Health is playing a major part in the whole financial management agenda and, indeed, in driving efficiencies through Government as well.

Mr. A. Lane:

When will you expect to be fully compatible with changes there?

Finance Director:

Sorry, please say again?

Mr. A. Lane:

When will you expect to be in compliance with all the changes?

Finance Director:

The changes of the law, we will be compliant with the law from the day it is effective, obviously, because it is a legal requirement. Again, we will train our colleagues. They have all been trained. We are currently working with assistant medical directors to get training devolved out into the service as well as to the accountants as well. That inevitably takes a little bit of time. It is like My

Conversation My Goals, it is embedding it with some really enthusiastic and keen colleagues and we have a regular training programme with them.

Mr. A. Lane:

Thank you. Can you tell me how you think the public experience of H.C.S. will change in the next 6 months?

Director General of Health and Community Services:

So our biggest piece of work that I think will impact upon patient experience is the work that we are going to be doing around our waiting list. Previously, we have not had a way of tracking where patients sit on our waiting list, what is commonly known as a P.T.L., a patient tracking list. We have not had that, so we have not been able to deliver the service we would want to deliver around ensuring patients know when they go on the list, what is their date on list, time on list and when they are going to get a date, and putting a standard around that. We still have not put a standard around it, but what we do have now is a patient tracking list that is being rolled out to services. At the moment it is in the process of being validated, but we are more or less there with that. That will enable us to start managing our waits so that we can start to deliver care in a timely fashion, which we do not currently do across all our services. So I think the biggest impact in the next 6 months will be that patients will start to see some organisation around waiting times.

Mr. A. Lane:

You do not yet have a standard. When would you expect to have a standard and how will you set it?

Director General of Health and Community Services:

We have introduced something called our I.P.R. (integrated performance report), our performance report, which has all of our standards on there. What it does not have is waiting time standards because Jersey is not the N.H.S. (National Health Service), we do not have referral to treatment, and neither would we want to follow that so that we were delivering care just by rote. But what we do is we want to give the public a measure, an expectation which they can measure timeliness by. I anticipate that we will have that in place by April next year. I would hope for sooner, but if I am being realistic validation of a list that has never existed and then the management of that list utilising the capacity we have will take us 3 months to get on top of it and to get people used to managing and recording to a tracking list.

Mr. A. Lane:

Thank you. You have accepted that the governance systems were overly complex for a population of 100,000. What have you done to streamline those?

Director General of Health and Community Services:
So we have taken our governance processes and thrown them in the air and completely revisited them. The C. and A.G. was absolutely right. Our governance processes were not fit for purpose and did not deliver the assurance that we are obliged to deliver for the care we are delivering to the people of Jersey.

[14:15]

So we have started right from the bottom up and we have sat down and we have looked across multiple examples of health economies, both in the U.K. (United Kingdom) and in France, and around what it is that we need to deliver to ensure we have a governance and assurance framework. So we have created 3 committees: our Finance and Modernisation Committee to ensure that we have probity around the utilisation of our money and our transformation agenda. We have a Quality, Risk and Performance Committee, which ensures that the care that we deliver for our patients is timely, qualitative and that is risk assessed so that we are aware of the challenges we face in order to deliver qualitative service. We have a People and Organisational Development Committee because probably our biggest risk in H.C.S. is the management of our workforce and how we ensure that we deliver sustainable care going forward with the challenges we have, which are national challenges, around recruitment and around retention. They then feed through to our board. We have a H.C.S. board. We have now met 4 times and we meet in public. We have a really - I think we have shared our structure with you - clear escalation around what comes from ops group to committee to board. Previously, all the committees were chaired by me, my post - I was not in post - which in effect was me asking if we were doing it okay and me telling myself that we were. So we have changed that and we now are chaired by our Assistant Ministers, who although they are our ministerial team very much sit outside the day to day business of H.C.S. and are able to hold us to account around the care we deliver and, indeed, ask the questions that members of the public would ask us but also hold me to account.

Mr. A. Lane:
Thank you. So you have done work to simplify the structures. It seems there is probably a lot to do still on cultural change, which is going to take longer. What are you doing about that?

Director General of Health and Community Services:
So that is a very big one and I wish I could say I had or we had a magic wand around that. Rose, do you want to talk about some of the organisational structures and some of the work that we are doing around nurse leadership and clinical leadership?

Chief Nurse:

Mm hmm. So we recognise that probably over the last 18 months across the whole of Government we have gone through significant change the like of which we have not been through before. Within H.C.S. that change has really started to come into effect this year. So while we have completely restructured our governance arrangements, we have also restructured how we deliver care. What we have really worked hard to do is to start to really see the golden thread from what happens on a ward right up to the board. So some of the things that we have done, and I have brought copies for you today because I do not think they were submitted before, is we introduced a system called Jersey Nursing Assessment and Accreditation System. Probably about 2 years ago we started to implement it fully and we have developed this system working with an N.H.S. foundation trust that was commended for the work that they had done on this by the C.Q.C. (Care Quality Commission). It is basically a series of standards, 14 standards, 240 in total I think it is, that wards are assessed against in relation to the quality of care that they deliver. So this piece of work across all of our inpatient wards and also in some of our provider organisations has really started to take a step towards changing the culture. So the way this process works is a team from my office go into those clinical areas unannounced. All the wards know the standards so they know what is expected, and they will undertake a visit on a given day where they talk to patients, they talk to relatives, they assess practice, they observe practice and they talk to staff. So they triangulate what they are seeing and what they are hearing. They are then assessed against all of the standards and the scoring mechanism that we use is the same as the C.Q.C. use in England, and then they are given a rating. They will either come out at a green, an amber or a red. If they come out as a red or amber, they are revisited more frequently. Those reports then go right up to the top of the organisation, so they are seen at board. That is just an example of one way in which we started to see a shift in the culture change.

Mr. A. Lane:

So that is wards and nursing. What about surgery, operating theatres, ancillary services?

Chief Nurse:

Yes. So in addition to that … so that is one example. Another example is as part of our new governance arrangements we are undertaking what is called performance reviews. This is where we meet with the associate medical director who runs the care group, his lead nurse, the lead A.H.P. (allied health professional) and their general manager, and myself and my colleagues in the executive. So myself, group managing director and the medical director sit down with these teams and we look at the activity. So we look at the waiting times. We look at the patient safety incidents, the complaints, we look at their J.N.A.A.S. (Jersey Nursing Assessment and Accreditation System) scores. So we discuss with this team how they are performing. That sits alongside of our governance processes as well, and again we are on a journey in relation to this. So some of these

areas we have not had this information before. As people are starting to see the information and understand the information, they are then able to use it to improve services as well. So that is much broader than just nursing. That includes all the professional groups.

Mr. A. Lane:
Is that feeding its way into the various boards and committees?

Chief Nurse:
Yes, yeah.

Senator S.C. Ferguson:
What about the basic cultural problems that you have had in health, the bullying and the harassment and the blame culture? How are you managing to cope with that?

Chief Nurse:
I think in relation to our new structures we are absolutely open to anybody who wants to raise anything with any of us at any time. Our new structures have really flattened the hierarchical structures that we have had in the past, so we have much more of a clinical leadership model in the organisation. So instead of being an organisation that is generally management led, the organisation is being led by clinical and professional leaders supported by a new whistle-blowing policy, supported by all of our various codes that we have, supported by an anonymous helpline. If people want to raise concerns anonymously that is in place as well. All of that is sitting alongside the Team Jersey work. So we have Team Jersey champions that are trained, that are out in practice. We had a Team Jersey launch recently. All of the executives supported the Team Jersey leads in that launch and we were out in all the different departments talking to staff about what it feels like working in the organisation. So again it is constant work that you have to do in relation to culture.

Director General of Health and Community Services:
It is about clinical leadership. So it is so … what we are trying to do is so different for H.C.S. and it is about the hand that touches the patient being at the helm of the ship, that intimacy. Previously in H.C.S. decision making came from the 4th floor of Peter Crill. We have moved away from that. I am not omnipotent. I do not know everything there is to know about health. I would not want to and I would hope the people of Jersey would not want me to be the soothsayer of health because that is dangerous. What I am is the accountable officer so ultimately I am on the line. We work now through an executive tri. So the people who operationally guide the organisation are the Chief Nurse, the General Manager and the Medical Director working as a tri. That is replicated through the care groups. There is a tri in every care group and assurance comes through the group, committee and board structure of which I am one member of a team, although the accountable

officer, so that you get that multiplicity of voice. What we have not managed to do successfully yet - although we have managed it at board with a patient story but it is the patient's story - is we have not done co-design with patients. We do not have the patient voice through our governance structure and that is the next piece of work that we have to really focus on.

Mr. A. Lane:
One last follow-up on that area: how is whistle blowing making its way to the boardroom?

Director General of Health and Community Services:
That comes via the Chief Nurse. So we have the whistle-blowing policy, and did you just want to talk about how we are rolling that out again? Again, it is embryonic and it is a new process for us. You can have a policy but then you also have to have the confidence of staff to feel that they can whistle blow and will not be identified or penalised. So do you want to talk about some of the work you are doing with the nursing staff around that?

Chief Nurse:
Yes. So in relation to whistle blowing, so when the new whistle-blowing policy was launched a number of the executives went out and spoke to staff and explained what the new policy was. In addition to that, we have a whole piece of work around wellbeing of which raising concerns is a significant part of that, because obviously if people are stressed about something at work, that can affect their performance. So we see that very fundamental to our wellbeing strategy and, again, that is run through the People and Organisational Development Committee. So there are a number of different mechanisms in place in relation to supporting staff in practice, not just in relation to whistle blowing but in relation to how people raise concerns.

Director General of Health and Community Services:
But do they feel confident to do that? Do they feel able? Do they know enough about it? No, we are not where we need to be, but again we are at the start of a journey to that. So it is very much a piece of work that we have to do across H.C.S. I would hope that when you see us in 6 months we have a live, thriving culture of whistle blowing. We are already moving to a culture now of Datix being used so we are becoming an organisation where, thank god, Datix is becoming onerous because that is what you want. You want as much on there as possible.

Mr. A. Lane:
Datix?

Director General of Health and Community Services:

Sorry, it is our system whereby our staff can go on and they can talk about any risks that they may have identified.

Chief Nurse:
It is a web-based incident reporting system that is widely used in the N.H.S. and it is real time.

Mr. A. Lane:
Thank you.

Deputy I. Gardiner:
It looks like you have a number of options that staff can go and share their views.

Chief Nurse:
Yes.

Deputy I. Gardiner:
There is a place for whistle blowing and complaints. I would like to ask if you have recent examples of how this type of sharing improves your services.

Chief Nurse:
Think of some examples …

Deputy I. Gardiner:
From complaints, from whistle blowing, from staff sharing, something that you received and it has improved the services.

Chief Nurse:
So we have a number of different examples. We have an example … so not all in relation to complaints but in relation to feedback. Certainly, our last patient story that came to our H.C.S. board the board has videoed and we have used that footage to share with nursing leadership in the organisation with a view that then they use that patient story to share across the workforce so we take the learning from it. So some of the story that that gentleman shared with us was around day surgery services and how while he felt the clinical treatment he received was as he would expect, he felt that perhaps he was processed rather than had those softer skills from the nurses and the time from the nurses in relation to his interaction with them. So that is something that nursing is taking forward. With every complaint response now that we send back out in the organisation we make sure we include learning in it. That was not necessarily the case previously. So we did respond to complainants in terms of how we had investigated their complaint but we did not always

say what we had done to stop it from happening again. I have quite a few examples that I can share but I do not …

Deputy I. Gardiner:
That is okay. Risk registers would identify that in a number of ways. Can you briefly explain what you have done to improve them? How does that improve outcomes for the patient?

Director General of Health and Community Services:
It is the tool by which we run our business, or should be, and is more and more becoming that for us. So we had to do a significant piece of work in order to validate our risk register and we kicked off that piece of work probably about 5 months ago. We now have a validated risk register. We are routinely evaluating all lists scored at 16 above at management executive, at quality and performance committee and at board. We intend to start publicising our risk register so that members of the public are able to see the challenges that we face. We are cascading it through the organisation. One of the challenges we have is around having risk management training at our base levels and that is a piece of work that we are focusing on now. But our risk register is very much a live document that we use to make decisions around how we spend our money, around how we make service improvement and how we decide what outcomes we want to fund around our patient care.

Deputy I. Gardiner:
When will you publicise it?

Director General of Health and Community Services:
It has currently gone to private board. It will go to public board November and we intend to start publishing I think from January.

The Connétable of St. Mary:
All right. When do you plan to report complaints publicly?

Director General of Health and Community Services:
We want to. I do not think we have a time for that yet, do we? I am looking at Rose, who is the exec director leading on complaints.

Chief Nurse:
Yes, we have not set a timeframe. We have recently appointed a P.A.L.S. manager, a patient advice liaison service manager, which was one of the recommendations in the C. and A.G. report. As part of the new developing P.A.L.S. service we want to produce a whole patient experience report that

includes complaints, feedback, you said, we did. She is developing that piece of work at the moment so I think it will probably be next year before we are in a position to do that.

The Connétable of St. Mary:
So it is something that is in progress?

Chief Nurse:
Yes, absolutely.

Director General of Health and Community Services:
Absolutely.

[14:30]

The Connétable of St. Mary:
Thank you. Resourcing and workforce relations. The C. and A.G. raises issues in the report on adult social care about reliance on temporary staff in leadership positions, workforce disengagement. Given recent issues with strike action, please outline what actions have been taken to engage the workforce in H.C.S. How is this being monitored and tracked to ensure higher levels of engagement?

Director General of Health and Community Services:
So some good news around adult social care. I will ask the Chief Nurse to update on our current recruitment.

Chief Nurse:
So just in relation to your first point around interim staff in senior leadership roles, I can confirm that across our tier 3 roles, with the exception I think of 2 posts, they have all come from within H.C.S. So our care group leads, our associate medical directors, were all recruited from our existing workforce. I have a couple of people in act up roles at the moment just while we are waiting for the substantive post holders to come in, but they are people who were already in our workforce who have stepped up into that position. In relation to our ongoing recruitment, I have to say it is always a challenge. I have been here for a number of years and it is something that you never take your foot off the gas on. As you are very aware, the N.H.S. is struggling with vacancies at the moment and we are very much part of that whole pool of recruitment. We have had some real positives, though, in mental health services. We managed to recruit 3 consultant psychiatrists very recently who have all started and are in post. We have also recruited a number of nurses into mental health

services, but we are still carrying some agency staff across some of our areas. We will continue to do so until we have recruited and it is safe to remove those temporary staff.

Director General of Health and Community Services:

We have recruited a chief social worker so we no longer have an interim head of social care. We have a chief social worker who will be starting with us in January and is a very good appointment for us. We do still have interim staff and I am not sure I can see a point where we would never have no interim staff, although that would be our aspiration. But I do think that sometimes there is a need for interim staff because they bring a different kind of capacity, a different kind of capability when we have gaps in service, but our intention is to have substantive staff across particularly our leadership team.

The Connétable of St. Mary:

Have you identified areas as to why it is difficult to recruit from outside the Island?

Director General of Health and Community Services:

Having come from 30 years in the N.H.S. and the last 10 years being particularly difficult, I think it is an endemic issue around healthcare. There is information this year that shows that less people are choosing to go into medicine, so it is difficult to recruit. We do have plans in place in order to be able to grow our business so that we can have more of a caseload that would encourage clinicians and nurses to come and join us, so that there was more variety of work. We have intentions to bring work back on Island that we think we can do here on Jersey, which would encourage people to come and work for us. We are looking to grow our own, very much so, so we are looking to do … well, we have been doing some mentoring but we are doing a lot of work with Highlands around how we can start to grow our own staff and offer opportunities to people. One of the issues I think is you cannot be what you cannot see. My aspiration is I am not sure it will be the next me but the next-next me should be a Jersey person, but the only way we can do that is by getting people in to see what we do and to see how you do the job. Because if you do not have the opportunity to go and run a healthcare economy somewhere else, you need to get close to someone who is doing it on Island because you do not necessarily need to be a healthcare specialist to do my job. So that is the kind of conversations we are trying to start having.

Chief Nurse:

So just to add to that if I may, just as an example we have 54 student nurses in training at the moment. We have a contract with the University of Chester; 45 of those are general adult nurses. So these are the nurses you see working in the general hospital. Then smaller numbers are mental health nurses, midwives and children's nurses. That is a programme we run each year. We also offer people on the Island a return to nursing course, which is validated with the Nursing and

Midwifery Council and the university. That is really trying to attract people back to the profession who perhaps had a break because they had a family or they had a change in career. We are also looking to develop our home-grown social workers. So where we have gaps in provision, we are looking at what we can do locally as well. In relation to the sort of broader piece and your question around what sort of broader things you need to do, we are engaged in a piece of work around key workers, which is really targeted at the moment around accommodation issues that people have when they move to the Island. We are working across Government on that piece of work, but there needs to be a bit more work around the whole key worker piece which aligns our education offering, our on-Island training programmes, so that it is equitable across any pay group, not just within health but anywhere that Jersey is struggling to bring people into the Island. What can we do as a Government better to make sure that we have a much fairer system and offer people locally some really good careers in Jersey? So that is just a bit of a broader piece of work that we have done. But we are sitting in the backdrop of an N.H.S. that has 40,000 vacancies at the moment, so we very much mirror what is happening elsewhere. We do our best to get on the front foot around recruitment. We do our best when people apply. We do not batch applications anymore. If you apply today and you send your C.V. (curriculum vitae) in and you look like you are somebody that we would like to recruit, we will bring you forward. We will get a hold of your hand and we will pull you through rather than wait until we have sort of 10 applicants because you lose them to other N.H.S. trusts. So our nurses and doctors and other pay groups are doing everything that they can to recruit.

The Connétable of St. Mary:

Thank you. The C. and A.G.'s first recommendation in her original 2015 report, review of community and social services, was to not only establish clear milestones for the implementation of a governance framework but also to monitor delivery against those milestones. What have you put in place to monitor the success or failure of the initiatives?

Director General of Health and Community Services:

Community services now, since we have restructured, is a part of Health, so it is one structure with our T.O.M. So our governance structure works across Health, the hospital and the work that takes place in our community services, so it is what I have previously talked about, our committee structure, our board structure, and in that process around the performance reviews monitoring against the key metrics and the governance that we have in place. So those reviews happen monthly, as does committee and as does board.

Chief Nurse:

Sorry, just to add something to that as well - there is just so much - we also introduced a board secretary role, which really supports us as an executive and an organisation to make sure all of the

threads are pulled together. Because it is quite a big piece of work to make sure that what we discuss in one committee is tracked through to another committee and then ultimately makes its way up to board. So at the moment where all the committees are serviced by different people, the board secretary has the overarching handle on what is going on in all of the committees and has that oversight, also a weather eye to the C. and A.G. tracker document that we have in terms of making sure we are meeting our recommendations. We have also built in a 6-month review of our new governance process so we can evidence and demonstrate that we are doing what we have said we have done as an organisation.

Director General of Health and Community Services:
That is pivotal. In fact, you should just listen to Rose. The board secretary is the pivotal role and Bernard Place has been doing that for us for the last 6 months and has done a fantastic job around really holding it in his fist.

The Connétable of St. Mary:
Thank you.

Mr. T. Rogers:
The Committee is pleased to note the long-term plan to develop a social work degree on Island. It has also welcomed the recruitment initiative of mental health services to support a significant reduction in agency nursing staff. However, it is concerned to note that there is no mention of a timescale to introduce similar initiatives to other areas such as residential care workers. Could you tell us a little about that?

Chief Nurse:
Could I just check with the residential care workers, this is specific to adult social services, is it?

Mr. T. Rogers:
Mm hmm.

Chief Nurse:
Okay. I must admit I am not particularly cited on that from a recruitment point of view. However, in terms of whether or not there is a specific issue with that pay group in the same way that we know with the issues around some of the other pay groups, I would need to come back to you with some information on that.

Mr. T. Rogers:

Okay. You mentioned earlier the establishment of the People and Organisational Development Committee. This is a positive step, but how does it address chronic staffing levels throughout Government's community and social services?

Director General of Health and Community Services:
We are in the process of establishing a workforce plan, which we have not had before in H.C.S. That workforce plan is seeking to understand where we are now, where we will be a year from now, 3 years and 5 years, and identify the gaps around the workforce but also start to identify different kinds of workforce. While we recognise that it is difficult and it is predicted to become increasingly difficult to recruit certain staff groups, how can we deliver care differently, and that is also tied in with the work that we have been doing around the Jersey care model, which is the model we have proposed to the States, around how we can utilise different parts of the community who already deliver care to wrap around care delivery. That is all part of the work that happens within People and Organisational Development. We hope to have that workforce plan. Again, my understanding is that that is going to be ready by the end of the first quarter so that we will be able to share that with colleagues.

Mr. T. Rogers:
Thank you. The P.A.C. welcomes the work undertaken to establish clinical and professionally led care groups who drive workforce engagement. What do you have in place to measure this?

Director General of Health and Community Services:
To measure engagement?

Mr. T. Rogers:
Yes.

Director General of Health and Community Services:
I am not sure that we have anything robust in place to measure engagement. No, we do not.

Chief Nurse:
Yes, sorry, if I may, what we do have is we do have evidence of engagement. Particularly around our consultation around our target operating model, that was an extensive consultation and we received more feedback for our department target operating model than the whole of Government received when they went through the change. We ran significant road shows, one to ones with staff, and similarly we have done the same around some work we have done on a Jersey care model over the course of summer. So what we do have is evidence of activity of engagement, evidence of numbers of staff that we have spoken to, evidence of the executives going out into other areas that

perhaps we do not normally reach, the laundry being a great example that we all went to at different times and it ended up a little feature on television for them. So we have evidence of that, but in terms of measuring what difference that has made we do not have that at the moment.

Director General of Health and Community Services:
We do not have a formal engagement strategy. All of that is great, Rose, and we are doing … I suppose the most formalised thing we have started doing is exec visits, but again they can feel a little bit like casting roses in front of you. So it is a piece of work we have to do. Without wishing to make excuses, we have spent the last 6 months working out how to measure our activity, measure our performance, measure our waiting times, get the real basics right, and it is absolutely something that we need to do. We do need to have a formal engagement process for staff that they are able to co-design with us and be part of. That sits with P.O.D. (People and Organisational Development Committee). I think that is another 6 months' work for us to have something meaningful.

Mr. T. Rogers:
Okay. Thank you very much.

Comptroller and Auditor General:
Can I just come in because I suspect you have gone a little bit more than you think you have in terms of engagement? Because I am sure you are already doing elements of it: exit interviews, perhaps talking to people as they leave and finding out why they are leaving.

Director General of Health and Community Services:
Yes.

Comptroller and Auditor General:
I do not know whether you have conducted any staff attitude surveys but that is certainly something that you could begin to think of in the near future. I am sure you look at turnover, staff turnover, which can also be used as evidence as to how effective engagement is. Obviously, I am sure you are beginning to think now as well about illness of staff as well and all of the things that are influenced as you begin to engage much better with staff. So I suspect you already have some elements that you could begin to build into that.

Director General of Health and Community Services:
Thank you for that. I think we still are challenged by the H.R. (human resources) data. We are unable to say how many people we employ definitively. So while I think we do definitely do exit interviews routinely, part of P.O.D.'s work is for us in H.C.S., while working with Government, to try and get some robust information. Because where we have seen dividends elsewhere around

improving what we do is around our real focus of getting information to manage by, which we have not had previously.

[14:45]

That is one of the real focuses of P.O.D. and that is the point of getting a workforce plan in place that (a) we know how many bodies are out there; (b) we understand what their contracts are; (c) we understand when they are going to go and if they are going to go and why they are going to go. Then we can start planning.

Senator S.C. Ferguson:
And how many times they are off ill.

Director General of Health and Community Services:
Yes, absolutely, and why, yes.

Senator S.C. Ferguson:
You do not happen to know whether your average is higher than the standard average?

Director General of Health and Community Services:
I think we are at 4 per cent.

Chief Nurse:
Yes, I do not think we are an outlier.

Director General of Health and Community Services:
I think it is 4 per cent. I do not think we are an outlier. Again, that is work that has come out of P.O.D., which has been really valuable getting that number right.

Senator S.C. Ferguson:
P.O.D.?

Director General of Health and Community Services:
Sorry, People and Organisational Development Committee.

Senator S.C. Ferguson:
Thank you. It is a bit like what exactly is your T.O.M.?

Director General of Health and Community Services:
It is our target operating model. So it is our structure, our organisational structure.

Senator S.C. Ferguson:
Yes, we have heard various definitions. One of them was that it was a concept.

Director General of Health and Community Services:
I do not think it is a concept. It is an organisational structure that is called a T.O.M.

Chief Nurse:
We included it in the P.A.C. submission. There is a diagram in the … that is our leadership team. So there is a diagram. I brought copies because I do not think this was included in the submission, but this is our tier 1 to 4 leadership team. Then we have the care group structure. So all of that together is our new target operating model. So I can leave those with you.

Senator S.C. Ferguson:
Thank you. Adrian?

Mr. A. Lane:
We met the Chief Executive 4 weeks ago who told us quite a lot about the paucity of I.T. (information technology) infrastructure within the States. I wonder if you could just tell us something about how that is impacting on your ability to move towards your target outcomes.

Director General of Health and Community Services:
It is difficult. We have been fortunate to have somebody who is a health analyst, who works for us and has focused an incredible amount of time on getting data for us. That was my main focus when I came into post was that you need data in order to be able to make safe decisions. So he has done a great deal of work pulling together H.C.S. data so that has helped us, but absolutely we are very, very challenged around understanding our business. We are much better than we were, in a much better place than we were 6 months ago. I could give you a whole ream of information that we now have to manage by, which is fantastic, but it is not where we need to be.

Mr. A. Lane:
Could you give us maybe the 2 or 3 biggest improvements you have seen in that space?

Director General of Health and Community Services:
There are so many, are there not? So knowing about our activity, understanding what comes through our front door, what the presenting conditions are, what the split is, understanding our

outpatient activity, where it is, what the split is, our new to follow-up rate, what is urgent, what is not urgent, understanding what is going through our theatres with more granularity so we understand our start times, our finish times, our turnaround times, understanding about our theatre scheduling, right the way from the front door to the back door and length of stay. So outpatients, diagnostics, E.D. (emergency department), on the table, length of stay, out the door, D.T.O.C. (delayed transfers of care), much better information. To me the biggest thing - but it might be because it is the newest - is the patient tracking list. Finally, I can pull up a waiting list and I can see every patient who is waiting for care from H.C.S. I can filter them, whether they are urgent, routine or soon. I can see the clinician they are waiting for. I can watch on the list who gets listed where, proper transparency of waits.

Mr. A. Lane:

What else is on your wish list or would be transformational from a technology perspective?

Director General of Health and Community Services:

There is so much. I think for me what would be transformational would be an electronic patient record. That would revolutionise the way we work. We are still dependent on too many bits of paper. We still have a multiplicity of people wheeling notes around the building in trolleys and it does not … you can be as slick as you want around waits and you can be as slick as you want around delivering efficient care, but if you cannot find the patient's notes when they come in to see you, you are going to give them a rubbish experience. Unfortunately, we do that too often. So for me an E.P.R. (electronic patient record).

Mr. A. Lane:

Have you been able to put something into the Government Plan for that?

Director General of Health and Community Services:

Yes, that is all sat as part of the money around the I.T. infrastructure.

Senator S.C. Ferguson:

Do you have the costing side, for instance, for operations on the private side … have you sorted out the costing side yet?

Finance Director:

Yes, there was a review in March 2017. There is another review kicking off now in preparation for 2020. We have the income analysed by the category and we have, as I am sure you are aware, the P.L.I.C. (patient level information and costing) system, which is backed up by documentation. But

we are not just assuming it is all right, we have instigated colleagues to do a further review now to impact on 2020.

Senator S.C. Ferguson:
Do you have standard rates for operations?

Finance Director:
They do use standard rates. You can use standard rates; you can use actual rates. I am not 100 per cent personally certain but I believe it is standard rates here. I can confirm that for you.

Senator S.C. Ferguson:
No, I am thinking in terms of if you are going in to have your appendix out or something, somebody will say: "Right, well, unless there are complications, from start to finish it will cost X pounds."

Finance Director:
I appreciate that is my understanding of what we do. I have not personally seen that. I would have to just confirm that for you.

Senator S.C. Ferguson:
Was it President Reagan who used to say: "Trust but verify." **[Laughter]**

Director General of Health and Community Services:
We are just getting into - I think we talked about it in another committee - again we have work streams, and private patients is one of our work streams, to get down into the detail of it. What our theatre work is … so at the moment one of our work streams is theatres and around understanding our efficiency and their utilisation and seeing what the art of the possible is and, as I talked to you the other today so I do not want to bore you, how we can mix this round so we can get dedicated private lists and a dedicated private theatre. Because at the moment it is hard to measure because it is mixed in, but once you have dedicated private lists you can measure their utilisation. You can cost it up so it becomes your order book and say: "That private list is going to bring in 15 grand and 3½ grand of that is going to be for H.C.S." Then we can start to forecast around our income. But to do that we had to get the theatre work done first to understand what we are doing on the table.

Deputy I. Gardiner:
Moving to efficiencies, the C. and A.G. recommended that you have a structured approach to identify and implement efficiency savings. Can you please describe how did it work and how did you feed into the current Government Plan?

Director General of Health and Community Services:

So we used information. What was great about having somebody in post who was able to start understanding our activity and presenting that information back to us and us being able to share that with our teams, that we were able to start to see where the inefficiencies were and where that gap was. We have many inefficiencies within H.C.S., not intentionally but because we have never had the information to identify them. That is how we started to see the opportunity. Both through efficiencies this year but what we are … we are instigating the culture of pipeline next year. So in our cost improvement meetings if somebody brings forward an efficiency which we have identified through our information … and all of them are signed off by our Chief Nurse and Medical Director to see the quality impact. Is this going to impact on patient care and outcomes? In what way? If it is negative, we are not doing it. Can we do it this year? If it is 50 per cent that is not inefficiency. If it is 80 per cent we will put it on the tracker. If it is less than 80 per cent, we will put it into next year, into our pipeline. So, starting to get our teams to think about what they are doing every day, supported by information and how they can do it better. This is not about taking money out of health and cutting, this is about delivering what we currently do but more effectively.

Deputy I. Gardiner:

I agree. Can you give an example of efficiencies that we will find in this new Government Plan? I know this has been published but I still have not seen it, to be honest. I did not have time to open it.

Director General of Health and Community Services:

We have lots of what I would call easy wins around contract management, around off-Island contracts, patients that we send off Island and the money that we pay for them, negotiating them better. Similarly, with work that we send to the south coast, starting to manage that and negotiate and manage the contract, meet up with people to talk about the money we are paying, not just pay the money and never see them. But also about looking at all our maintenance contracts, our supply contracts, all of that back office stuff that we have never really done before, which does not impact upon patient care, does not impact on staff and allows us to pull money out. Then some of the much bigger work, which is about working differently, particularly around theatres and around outpatients. We have identified as part of our care model work that there are 40,000 outpatient appointments that do not need to be in an outpatient setting. We do not need to drag our patients into St. Helier. They can be seen in primary care. They can be seen in the voluntary sector and we can influence that by having a commissioning framework which involves that caretaking placed in organisations that do not have the substantial overheads that we do on Gloucester Street so, therefore, sharing efficiencies across the health economy.

Deputy I. Gardiner:

Yes, you should be sharing efficiencies, I am completely with you. The question again is the voluntary association: how would you be monitoring that the procedures and safeguards and staff is in place?

Director General of Health and Community Services:
We would have a proper commissioning structure. We do not currently. At the moment we have a contract and we pay a certain amount of money, but what we do not have is what we would want going forward, clear K.P.I.s (key performance indicators), clear quality indicators, clear governance that replicates our governance within H.C.S. So we have started to have metrics at our Quality and Performance Committee from our contracted … the services, external voluntary services, that we contract to. So, early days so we can start to see what the quality measures are. Then we would have monthly meetings, which would be very clearly having the same I.P.R., which is holding to account in the same way we hold ourselves to account around the delivery of service, the quality of service and the outcomes.

Deputy I. Gardiner:
My worry, and maybe I did not catch it right, is that the patients are going and receiving services from the voluntary organisation that still is not standardised, that still do not have the standards that they need to meet. So when will it be done, basically, they are giving the services and services are meeting all necessary standards?

Director General of Health and Community Services:
If I am getting it all wrong, tell me. If I am commissioning you for a service and I have given you K.P.I.s with the indicators and the outcomes and I meet you …

Deputy I. Gardiner:
First you are giving K.P.I.s and you are checking that the voluntary service is meeting all standards?

Director General of Health and Community Services:
Yes.

Deputy I. Gardiner:
But we have the cases that the people are going now and receiving the services but the voluntary organisations are still not acting according to the standards because we still do not have them.

Director General of Health and Community Services:
We have been really clear from the start that we will be commissioning according to our own internal governance and qualitative standards and we would help … but recognising that for a long time in

H.C.S. we have held the money and the power, so we would need to help organisations to reach the required standards. I would venture that there is some work that we deliver that the voluntary sector would suggest does not meet the standards of care they deliver, so one of the first pieces of work we are doing in November - I think it is 8th November - is we are doing a co-design workshop with the voluntary sector to co-design our commissioning contract framework so we can start to talk as professionals across the health economy around what care and outcomes look like and identify the gaps in both our service …

Deputy I. Gardiner:
To bring it together?

Director General of Health and Community Services:
Yes.

Deputy I. Gardiner:
Okay. What progress has been made in understanding of the cost of care?

Director General of Health and Community Services:
Around the cost that we currently deliver?

Deputy I. Gardiner:
Yes.

Director General of Health and Community Services:
That is a challenging question which I am going to hand over to my Finance Director. **[Laughter]**

Finance Director:
We are doing a lot of work through the P.L.I.C. system that you probably aware of, which gets down to individual activity costing. We also do a lot of work through our budget monitoring, which is a very comprehensive document which meets with all colleagues. It used to be that it simply came to what was the management team. That is not the case anymore. It goes out to what we call our assistant medical directors. There is engagement between direct finance professionals and direct medical leads on getting to the bottom of things at a much more fine grain than there used to be. You can always do more of this. You can always develop this to the nth degree. There are always opportunities to do more, but yes, work is progressing on that.

Mr. T. Rogers:

I think you may well have substantially answered this question but I will give you the opportunity to extend any further points that you want to make. What is the impact on care measures as a result of efficiency savings either identified or implemented this year? You have talked at length about perhaps care is not compromised by these efficiencies. Is there anything that you want to expand upon that in terms of the effect on any care measures?

Director General of Health and Community Services:
I think it improves the standard of care that we deliver, particularly around timeliness. The majority of our work is about how we utilise our most expensive resource, which is our hot services, which is our I.T.U. (information technology unit), which is our theatres, which is our E.D., how we can absolutely maximise them to ensure that we are treating the right patients in the right place and that patients requiring hot services are in hot services and patients who do not are outside of that. But I cannot emphasise enough the purpose that we put around the Q.I.A., the quality impact assessment. Every single efficiency work stream has to be signed off by the Chief Nurse and the Medical Director or else I will not allow that scheme to go forward.

[15:00]
It has to demonstrate that any impact it has on patients is either neutral or preferably beneficial and I am confident that nothing that we are putting forward in our Government Plan is unachievable or will have a negative impact on patients. But I will turn to my clinical colleague to perhaps elaborate.

Chief Nurse:
Yes. We go through a formal process for each of the schemes. So we sit down with the teams that are leading on the schemes. We understand entirely what the scheme is about with the data as well. We then do a risk assessment that myself and the Medical Director jointly sign off. We do revisit those. So if during a particular programme there is a change or, as sometimes happens, the programme does not progress either at pace that we thought it would or there is a change in circumstance … so a good example is one of the programmes is around the bed reconfiguration in a general hospital. This is to do predominantly with refurbishment of the wards but also some of our reductions in length of stay. So that scheme was originally given a certain price tag to aim for in terms of cost improvement. The scheme has changed during the duration because there has been some slippage on timeframes in terms of the work in the hospital and we have revisited that from a risk point of view. So we would do that with any of the programmes that we are leading on. If there is anything that could be considered contentious, so if there is a scheme that involves workforce, we also put additional assurance mechanisms in place. We have done a lot of work around our nurse staffing establishments in the general hospital. We have put a controls and assurance framework in place around that, which takes place weekly. I have oversight of that as Chief Nurse. You will have seen in the information that was submitted a copy of our safe staffing report. What we have

been able to do through that scheme is to rebase our nursing establishment rotas so we have a much better skill mix, we are using our workforce much better, and we are in a position where our leaders of those wards have supervisory time to oversee care, to support their staff, develop their staff and make sure that quality and safety is paramount in those areas. So we have lots of different schemes in place. Another one is around contingent overspend but I could talk all afternoon and I will not.

Finance Director:

If I could just supplement that from a financial perspective, it is absolutely as the Director General says: nothing goes forward unless approved by medical colleagues. But the fact that we are saving some money in certain areas, some of our procurement colleagues are simply picking up the phone and being a little more robust with suppliers. That means we spend a little bit less. You get exactly the same product. Then that allows us to spend that money in other areas that benefit patient care and still bring the department within budget as required by the law. So you get a number of benefits from doing so.

Senator S.C. Ferguson:

Right. Any more questions?

The Connétable of St. Mary:

Could I just have a quick one? We mentioned patient records as being very inefficient. Do patient records need to find themselves up into operating theatres?

Director General of Health and Community Services:

To get up to theatres?

The Connétable of St. Mary:

I mean are they presented with the patient in the operating theatre?

Chief Nurse:

Yes.

Director General of Health and Community Services:

Yes. The patient is there with the patient notes and then you have the theatre notes as well. But the patient's notes are there because you need the patient's notes in order to obtain consent.

The Connétable of St. Mary:

It would be far more efficient if that was on screen for you?

Director General of Health and Community Services:
Oh, it would be transformational.

The Connétable of St. Mary:
So could patient records pose an infection risk?

Chief Nurse:
No, no.

Director General of Health and Community Services:
I do not think they can. I will bow to my clinical colleague …

Chief Nurse:
No, no.

The Connétable of St. Mary:
I was just trying to justify the urgent need. **[Laughter]**

Chief Nurse:
One of the greatest benefits around electronic patient record is that you do not have to have the single paper patient record in front of you to make a decision about a patient. So if a clinician has a patient in front of them and they want some advice from another clinician, they can access that information at the same time. That could be a G.P. (general practitioner) with a specialist in the hospital. We just do not have that at the moment and the information goes round in a green folder with the patient delivered by people.

The Connétable of St. Mary:
I think we all appreciate the urgent requirement, though, for an updated I.T. system.

Director General of Health and Community Services:
It would transform what we can deliver for patients.

Chief Nurse:
And staff.

Director General of Health and Community Services:

It would be revolutionary, and for staff. But the Chief Operating Officer is fully aware and fully behind and really has his boot behind it because he recognises the transformations that it would allow us to do, not just in the hospital but across the whole health economy.

The Connétable of St. Mary:
Thank you.

Senator S.C. Ferguson:
Super. Right, any more questions? Thank you very much indeed for your time. We do have one or 2 questions which would have allowed you to go on for about an hour and a half each but we thought that was a bit unkind, so if we can send them on to you for an answer in writing we would be grateful.

Director General of Health and Community Services:
Okay. Thank you for your time.

Chief Nurse:
Thank you.

[15:05]