Deployment of Staff Resources in Health and Community Services

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Contents

Summary

Introduction

1. The health and care system in Jersey is going through unprecedented demand pressure and change due to factors including an ageing population. The outdated healthcare estate is an additional challenge to providing efficient and effective healthcare. Two major programmes of work have sought to address these challenges, the new Care Model and the 'Our Hospital' project.

2. The Department of Health and Community Service's (HCS's) clinical and non-clinical management teams need to work closely with the frontline workforce to ensure that staff resources are deployed effectively and efficiently and in such a manner as to support delivery of the new care model principles and enable the effective use of the new hospital.

3. At 31 December 2021, 2,475 staff were employed within HCS, up from 2,371 as at 31 December 2020. This represents over 30% of the entire workforce of the Government of Jersey. The HCS workforce included 208 doctors, 713 midwives and nurses and 392 healthcare assistants.

4. Like all HCS staff, medical staff are crucial to the delivery of the changes required to achieve the new care model. More than ever during this period of change, clinical staff (including medical consultants) and staff in management positions have a joint responsibility to work closely together to provide the best possible healthcare within the resources available to them.

5. Job Plans are part of a consultant's contract of employment. They are an annual agreement that set out duties, responsibilities and objectives for the coming year. Effective consultant job planning is a key mechanism through which senior managers and consultants can agree, monitor and deliver effective services to patients and service users.

Key findings

6. The key findings from my review are as follows:

   - drafting of a HCS Our People Strategy has commenced and this sets out values and behaviours expected of staff in the department. The original intention had been to finalise this Strategy in the Autumn of 2022, but finalisation has been delayed as the Strategy is being revised in light of the *Review of Health and Community Services (HCS) Clinical Governance Arrangements within Secondary Care* report published in August 2022

- a primarily top-down approach to strategic workforce planning (involving Care Groups but not individual specialties within Care Groups) has been ongoing in HCS since April 2022 and is making slow progress. I have identified a number of areas that will need to be addressed in order to deliver an effective and comprehensive workforce strategy

- the pressure on inpatient beds, caused by high levels of 'medically fit for discharge patients' not being able to be discharged back into the community, is putting all parts of the Jersey General Hospital (JGH) and Adult Mental Health Services under considerable stress. Developing a workforce strategy and making changes to HCS arrangements in such a complex and stressful operational environment is going to be particularly challenging

- good medical staff engagement allows medical staff to contribute actively within their normal working role to maintaining and enhancing the performance of the organisation. The consensus among almost all staff interviewed as part of my review was that medical staff engagement was at best variable and was at worst, poor. Engagement is a two-way process. Best practice is for all healthcare professionals to work together for the common goal of delivering excellence in patient care. In my view it is essential for consultant medical staff in Jersey to recognise the everyday leadership roles that come with being a consultant. I consider that, if consultants recognised these consistently and if senior managers had better prioritised their initiatives to reflect the challenging operating environment in 2022 and were more skilful in managing consultants, then clinical engagement would be significantly better

- there appears to be a worsening of effective working relationships between consultants and staff in senior management positions, in several key areas. It is clear that the increasingly challenging system that both clinicians and staff in management positions find themselves working within has contributed to some of the behaviours that have led to this worsening of effective working relationships

- HCS has a well-established process for undertaking General Medical Council appraisal and revalidation, with a nominated clinical lead (Responsible Officer). However, the appraisal process to determine the individual consultant's contribution to HCS's organisational objectives is unclear. At the current time, the appraisal and performance management of medical staff in HCS are seen more as professional, rather than organisational, processes

- whereas job planning for medical staff has been proceeding during 2022, key elements that should underpin the job planning process have not been in place. Driving changes through at operational level, without firstly formally

agreeing the job planning policy and without key higher-level strategic agreements in place, creates a risk of both alienating and antagonising the senior medical workforce

- HCS has found it increasingly hard to recruit or retain permanent staff (medical and non-medical) in what is a challenging worldwide market for health staff since the COVID-19 pandemic. During 2022, HCS has increased its use of locum and agency staff. Running a service using high numbers of locum and agency staff requires management of a number of increased risks including increased costs and risks to productivity and safety

- HCS does not have a formal clinical supervision policy for permanent staff or for locum or agency staff. The clinical supervision that does take place is dependent upon the initiative of the individual HCS consultant. There is also a potential gap in the supervision of agency and locum consultants, who are not subject to structured 'line supervision' and may not be in HCS long enough for clinical audit and other forms of clinical governance to provide assurance

- there has been limited progress in implementing the relevant recommendations made within my predecessor's 2017 Report on *Private Patient Income: Health and Social Services Department Follow Up*; and

- while a Policy on Private Patients exists, the absence of a Government private patient strategy setting out clearly agreed parameters, management information and Key Performance Indicators (KPIs) regarding private patient activity, makes implementation of the Policy difficult in practice.

Conclusions

7. The Health and Community Services Department is under significant pressure currently. Factors that are contributing to this pressure include:

    - the ability to recruit and retain staff in a challenging market for health staff since the COVID-19 pandemic

    - inpatient bed pressures caused by high level of 'medically fit for discharge patients' not being able to be discharged from inpatient care into the community

    - lack of relevant data and management information to drive policy development and implementation

    - uncertainty as to the long-term strategic health plans for the Island (including the future care model and the Our Hospital project); and

- sometimes poor working relationships between senior clinical staff and staff in management positions.

8. In order to deliver and implement an effective and comprehensive workforce strategy, issues that need to be addressed include:

    - ensuring completeness and accuracy of workforce and clinical data and information
    - the future direction of the care model and the Our Hospital programme
    - finalising the structure of the Health and Community Services department (for example, the number and composition of Care Groups)
    - agreement of future clinical operating models at specialty level
    - resolution of policies in key areas affecting the workforce, including:
        - terms and conditions for particular staff groups
        - on-call policies and arrangements for medical staff; and
        - a private patient strategy
    - ensuring that enough specialist workforce planning capacity is available to support development of the strategy; and
    - effective project management of the future workforce strategy project.

Objectives and scope of the review

9. The review has evaluated:

- the progress being made in finalising and implementing a workforce strategy for HCS
- the effectiveness of the implementation plans supporting the workforce strategy
- the effectiveness of the proposed arrangements to monitor and report on progress being made in implementing the workforce strategy; and
- the effectiveness of the specific arrangements for the HCS medical workforce, including:
    - consultant and other medical staff engagement
    - the clinical management of consultants and other medical staff
    - the performance management of consultants and other medical staff
    - consultant and other medical staff job planning
    - arrangements in respect of locum medical staff, including clinical supervision, performance management and job planning; and
    - arrangements for management and oversight of the ratio of public to private patient activities.

10. The review has considered arrangements within HCS and not the wider health and social care system on the Island. The review has also not considered deployment of staff resources in contracted off-Island providers of healthcare.

11. The review has encompassed all specialities across HCS.

12. As part of the review I have followed up on previous recommendations made by my predecessor in her 2017 report *Private Patient Income: Health and Social Services Department Follow Up* where the recommendations are relevant to workforce planning and management.

Detailed findings

Government and HCS Our People Strategy development

13. The development of a workforce strategy within HCS is set within the context of the Our People Strategy development at a wider Government of Jersey level.

14. The States of Jersey Skills Strategy 2017-2022 was published in October 2017. While the health sector (including HCS) is one of the biggest sources of employment on the Island, there is limited reference to the health sector in this strategy. There is some reference to social care.

15. In October 2019, the Government of Jersey brought together key employers from across the Island to form the Jersey Employer Group (JEG). The focus of the JEG was to share good practice, create better workforce connections and develop Jersey-based talent. In June 2021, the JEG published *Developing a Strategic Workforce Plan for Jersey*. The challenges and opportunities facing the health sector are considered in this document.

16. In November 2021, the Government of Jersey published the Our People Strategy. This Strategy is not a plan to develop the workforce in terms of numbers and skills. It is instead aimed at developing the workforce through values and behaviours (referred to as Our Shared Responsibility). The Our People Strategy built on the values that had been developed and defined as part of the Team Jersey programme.

17. In my report *Governance Arrangements for Health and Social Care – Follow Up* (September 2021) I noted the difficulty that HCS staff have in owning generic values and initiatives that do not use health and social care service-related language. I recommended that the expected behaviours supporting the Team Jersey Values be redefined into a language specific to the delivery of health and social care services for HCS staff.

18. Drafting of a HCS Our People Strategy has commenced. The original intention had been to finalise this Strategy in the Autumn of 2022, but finalisation has been delayed as the Strategy is being revised in light of the *Review of Health and Community Services (HCS) Clinical Governance Arrangements within Secondary Care* report published in August 2022.

Work Planned that should be Prioritised

P1 Finalise the HCS Our People Strategy taking account of the recommendations made in the *Review of Health and Community Services (HCS) Clinical Governance Arrangements within Secondary Care* report published in August 2022.

HCS workforce strategy development

19. At its meeting in January 2021, the HCS People and Organisational Development (POD) Committee was advised of the plans to commence workforce planning within HCS. It was proposed that the maternity and pharmacy teams would pilot the approach.

20. In April 2022, development of a department wide HCS workforce strategy was commenced. The approach to development of this strategy is based on a six-stage methodology as shown in Exhibit 1.

Exhibit 1: Workforce strategy development methodology

Source: HCS workforce planning presentation April 2022

21. The progress made with the development of the strategy by the end of September 2022 is summarised in Exhibit 2. HCS is currently engaged in stages 2 and 3 through a series of workshops with divisions.

Exhibit 2: Summary of progress with developing the HCS workforce strategy at end of September 2022

Division	Stage 1 – Define the plan	Stage 2 – Analyse current workforce	Stage 3 – Forecast future needs	Stage 4 – Gap analysis	Stage 5 – Plan actions and strategies
Primary care	Complete	Complete	Commenced	Planned	
Surgical services	Complete	Complete	Commenced	Planned	
Medical services	Complete	Commenced	Commenced	Planned	
Women, Children and Family care	Complete	Commenced	Commenced		
Mental health	Complete	Commenced			
Adult social care	Complete	Commenced			
Facilities management	Complete	Complete	Commenced		
Non-clinical support services	Complete	Commenced	Commenced		
Medical director – corporate function	Complete	Commenced			
Innovation and improvement	Complete				
Chief Nurse – corporate function	Complete	Commenced			

Source: HCS report September 2022

22. I have compared the Government of Jersey corporate approach that is being implemented within HCS with recognised good practice from Skills for Health (*Six Steps Methodology to Integrated Workforce Planning*) and Healthcare Education England (*Workforce Planning within a System*). In overall terms, the six-stage approach being adopted by HCS broadly follows the practice recommended by Skills for Health and Healthcare Education England.

23. In summary, a primarily top-down approach to strategic workforce planning has been ongoing in HCS since April 2022. Progress is however slow. The earliest a high-level workforce plan could be produced is the end of the first quarter of 2023. If this is achieved it will be based on Care Group engagement, rather than engagement at specialty level. There is a risk that considering workforce planning at Care Group level could result in some key issues, such as clinical operating models and medical staffing models which can only be properly agreed at specialty level, being overlooked.

24. I have identified a number of areas that will need to be addressed in order to deliver an effective and comprehensive workforce strategy. These are:

- ensuring completeness and accuracy of workforce and clinical data and information
- the future direction of the care model and the Our Hospital programme
- finalising the structure of HCS (for example, the number and composition of Care Groups)
- agreement of future clinical operating models at specialty level
- resolution of policies in key areas affecting the workforce, including:
    - terms and conditions for particular staff groups
    - on-call policies and arrangements for medical staff; and
    - a private patient strategy
- ensuring that enough specialist workforce planning capacity is available to support development of the strategy; and
- effective project management.

25. I comment on each of these in turn.

Workforce and clinical data and information

26. A key issue that came up in many interviews undertaken as part of my review is the lack of clinical and workforce data and information and specifically the lack of a single, definitive source of data and information.

27. The HCS patient information system TrakCare was implemented in 2010. It records the number of procedures performed in a session or clinic but does not record who undertook the procedure (for example consultant X or Y, middle grade doctor A or specialist nurse B). In addition, the ability to identify whether patients

were publicly or privately funded is limited and requires a separate piece of analysis outside of TrakCare. While individual clinicians, teams and divisions may keep their own detailed data for clinical audit, research and private patient billing purposes, this is not centrally accessible in a data warehouse.

28. The result of this lack of validated data means:

- medical staff job planning can become contentious
- new clinical pathways and operating models can be difficult to design and agree
- the interplay between private and public patient practice is difficult to evidence; and
- any workforce strategy will have caveats around the data supporting its assessment of requirements.

29. I have previously observed in my Report *States Employment Board – Follow Up* (September 2022) that there are currently multiple systems to record workforce establishment within the Government and that People and Corporate Services records and Treasury and Exchequer records are not currently reconciled.

30. I note that a new HCS Electronic Patient Record system is due to be implemented in 2023. In addition, the Integrated Technology Solution to replace finance and Human Resources (HR) systems is also due to be implemented in 2023.

Future care model and the Our Hospital programme

31. The starting point for any workforce strategy should be the relevant and overarching long-term clinical or service strategy. However, as at the end of 2022 there are significant uncertainties over both the future care model and the Our Hospital programme.

32. Both of these programmes will have an impact on staffing levels and on skills and staffing structures required to implement healthcare in the future in Jersey. The speed at which changes are implemented and the order in which they are implemented will also have an impact on what changes are needed and by when within the workforce strategy. In the short term, the HCS workforce strategy may need to be based on the current estate (including the JGH building) with its associated constraints and pressures. This will however need to be balanced with ensuring that the strategy puts in place appropriate review processes to ensure that changes to workforce needs and expectations can be implemented as the future care model develops and the Our Hospital programme progresses.

The structure of HCS

33. Since 2019 there have been several changes in HCS management arrangements. Some of these have been externally required (for example 2020 saw the introduction of a centralised 'command and control' structure due to the COVID-19 pandemic). However, some have been internally initiated (for example, historic and ongoing changes to the number and composition of Care Groups). In addition, there has been a turnover of general managers within HCS. This has been reported in interviews as resulting in some clinicians not being totally clear what the management structure is, who makes decisions and what authority middle managers have.

34. Prior to the COVID-19 pandemic more decentralised and devolved management arrangements were in place, based on a clinically led leadership model which was implemented towards the end of 2018. During the early stages of the COVID-19 pandemic in 2020 HCS moved from this decentralised structure towards a more centralised 'command and control' structure in keeping with major incident management.

35. Since the 'command and control' management arrangements put in place during 2020 were relaxed, the departmental structure has changed and is still undergoing further potential change. All of these changes seem to have incrementally consolidated the departmental structure under larger Care Groups. Each Care Group is led by an Associate Medical Director (now called Chiefs of Service) supported by a lead nurse and general manager. This is known as a triumvirate model. Within these larger Care Groups there are several Clinical Leads at specialty level.

36. At the time of the interviews undertaken as part of this audit (September and October 2022) a further rationalisation of Care Groups, down from five to four, was proposed. This rationalisation would see the removal of the Women, Children and Family Care Group, with its services transitioning into either the new Medical or Surgical Services Care Groups. The timescales and final arrangements for the transitioning of services were however still to be agreed at the time of my review and were under further consideration.

37. One of the results of the changes over the past three years is that the constancy of structure and personnel, which would allow relationships and trust between staff in management positions and clinicians to develop, has been compromised.

38. Academic research highlights the importance of an embedded, well understood, fully integrated management structure, with low management turnover and trained, well developed, capable and empowered middle managers. For a variety of external and internal reasons these features have not been consistently present in HCS over the last three years.

39. In order to be effective, it is essential that the workforce strategy sets out the current and planned future structure of HCS, not least to provide certainty in this element of workforce planning assumptions.

Clinical operating models at specialty level

40. The JGH has approximately 200 beds and serves an Island population of just over 106,000 people. As a comparison, a small UK mainland District General Hospital would be assumed to have a catchment population of about 250,000. The smaller scale creates a number of issues for Jersey in considering the appropriate clinical operating models to adopt at a specialty level. These issues also have an impact in determining an appropriate workforce strategy.

41. Areas that need to be considered include the following:

- patients with very specialist needs are transferred to the UK, which means medical staff who wish to become highly sub-specialised are unlikely to be able to achieve that in Jersey

- alternative clinical consultant models have an impact on the skills required on Island. For example, one clinical model would be to have a high percentage of consultants who are generalists by training, but who take an interest in a particular specialist area. An alternative clinical model would aim to employ a wide range of specialist medical staff who are specifically trained in each clinical specialty. Finally, a third clinical model could result in a mix between generalists and specialists, according to clinical need. There are pros and cons for each model, but the key issue is that a formal decision needs to be made. The model chosen will impact significantly on the development of the future workforce strategy; and

- the preferred balance of consultants and middle grade medical staff on the Island. Evidence from interviews suggests some middle grade doctors (associate specialists, staff grades and clinical fellows) are contracted to work more than 16 Programmed Activities (PAs) each week. A PA is typically a half-day session and HCS's stated aim is to restrict the number of PAs worked to 14 each week. The alternative to using middle grade doctors is to have both a consultant led and consultant delivered service, with consultants supported by fewer associate specialists and staff grades and perhaps more clinical fellows and specialist nurses. As at the time of my audit, this strategic medical staffing decision has not been worked through or agreed. The lack of a defined way forward on such a key issue mitigates against HCS developing a robust and future-proof workforce strategy.

Resolution of policies in key areas

Terms and conditions of staff groups

42. Pay and wider remuneration form part of any workforce strategy, as they are key parts of recruitment and retention packages.

43. Historically the States Employment Board has created a specific employment contract for doctors and nurses, separate from other civil servants, with:

- separate pay scales; and
- contractual requirements to work evenings and weekends.

44. However, pharmacy staff, all therapists (for example physiotherapists and occupational therapists) and other relevant professionals (such as social workers and psychologists) are employed on standard States Employment Board civil service contracts with:

- standard public sector pay scales; and
- no contractual requirement to work evenings (after 5pm) or weekends.

45. These staff groups are however all vital to effective delivery of services to patients. They also have a significant impact on the efficient operation of HCS and on making sure patients have a good experience of care. For example, the ability to discharge patients on weekends is in part reliant on the goodwill of the pharmacy staff, who dispense medication to facilitate discharge, to be rostered to work as they are not contractually obliged to work on weekends.

46. There is a need to agree a planned way forward in respect of terms and conditions of key staff groups. This will impact on future workforce needs and should be factored into the future workforce strategy.

47. A further medical workforce issue that impacts solely on consultants is the treatment of medical indemnity insurance. In the UK NHS consultants are covered by their organisation's NHS clinical negligence (NHS Resolution) payments and only need to fund negligence insurance to cover their private patient activity. However, in Jersey consultants are required to take out and pay for their own clinical negligence insurance for both public and private work. All other HCS staff (including middle grade medical staff) are covered by the Government of Jersey insurance arrangements. Consultants can be fully reimbursed these costs, but only if their private practice income does not exceed 10% of their income from public sector work. This potentially creates:

- operational issues and inefficiencies in managing clinical negligence cases, as often restrictions are placed on the direct communication between senior, middle and junior medical staff and two legal teams are required to defend cases; and

- an unintended 'psychological barrier' between senior medical staff and the rest of HCS staff, as all other HCS staff are covered by a Governmental indemnity but senior medical staff are not.

On-call policies and arrangements for medical staff

48. A further key medical workforce issue stems from the policy and arrangements for being on-call. At the current time, on-call for surgeons (often one in three or one in four PAs) is not paid and instead time is given back in lieu.

49. The consequence of this policy is that different on-call rotas will generate different amounts of time back in lieu. In some cases, the amount of time given back significantly restricts the non on-call PAs available for consultants to undertake public clinical work.

50. I consider this issue further later in my report.

Private patients strategy

51. Whilst there is an approved 2017 Policy on Private Patients, the Government of Jersey does not have a private patients strategy.

52. The interplay between the delivery of public PAs and private patient practice has a number of dimensions. These include that:

- the opportunity to undertake private practice can be part of the motivation for consultants to work and stay on the Island

- it affects how HCS is operationally organised; and

- it is reported as the cause of some of the tensions between staff in management positions and clinicians.

53. A Government private patients strategy could set some parameters around the expectation of private practice on the Island. This could include an analysis of the impact to the public purse if those Jersey patients who can currently use private medical cover were to need to be treated as public patients. It could also set out the risks to consultant recruitment and retention if working on the Island becomes less attractive. Fundamentally, it could use these analyses to optimise decisions about private patient practice in Jersey and to identify and quantify the implications for hospital provision.

54. Implementation of a private patients strategy would have an impact on workforce availability and this needs to be addressed in the workforce strategy.

Specialist workforce planning capacity

55. The development and implementation of a workforce strategy for HCS will require specialist HR and finance support.

56. The wider HR service supporting HCS is made up of three separately managed elements:

- the Government of Jersey corporate HR function
- the medical staffing function within HCS which organises locum doctors; and
- the nursing function within HCS which organises agency staff.

57. The workload of these teams is significant and includes:

- operational HR functions for nearly 2,400 staff
- supporting management restructures when they take place
- organising very high numbers of locums and agency staff required to cover vacancies
- supporting complicated local staff contract arrangements
- facilitating medical Job Plans
- supporting a current retendering of the framework medical agency staffing contract; and
- supporting new HCS Workforce and Our People Strategies.

58. There is a risk that the work of the teams is not sufficiently co-ordinated and that the team supporting workforce development does not have the capacity or the experience to do this in an effective way.

59. To date, the finance team that supports HCS reports that it has not had direct involvement in the HCS workforce strategy project. This creates risks that the strategy will not consider strategic and operational financial control sufficiently.

Effective project management

60. There are opportunities to enhance the project management of the development of the HCS workforce strategy. For example, as at the time of undertaking this audit, no Project Initiation Document (PID) was available and no formal Project

Board had been established. The implementation of more formal project management could enable wider engagement and consequent buy-in to the strategy that is developed.

Recommendations

R1 Establish a Project Board to oversee the development of the HCS Our People Strategy and the HCS Workforce Strategy. In doing so ensure that:

- the membership of the Board enables appropriate oversight and appropriate clinical engagement; and
- appropriate formal project management and governance disciplines are implemented.

R2 Enhance the engagement at specialty level in the development of the HCS Workforce Strategy. In doing so, ensure that there is an agreed way forward for future clinical operating models and medical staffing models at specialty level.

R3 Clarify the planning assumptions that should underpin the HCS Workforce Strategy in respect of the future care model and the Our Hospital programme. Continue to review these planning assumptions as decisions are made with respect to the future care model and the Our Hospital programme.

R4 Ensure that the HCS Workforce Strategy provides clarity as to the future planned management structure of HCS.

R5 Review and, where possible and appropriate, negotiate a harmonisation of the terms and conditions of staff working in HCS. In doing so, seek to ensure the availability of the right workforce on a 24 hour, 7 day basis to support the effective delivery of services by HCS.

R6 Review the arrangements for the funding of clinical negligence insurance to ensure that they match the objectives of future clinical models and the future private patient strategy.

R7 Develop, publish and implement a Government of Jersey Private Patient Strategy.

R8 Ensure that the wider HR service, which is currently spread across three teams, is co-ordinated and that there is sufficient specialist HR and finance support within the team developing the HCS Workforce Strategy.

Arrangements for HCS medical staff

61. I have considered the arrangements in place for the deployment and management of medical staff within HCS. In particular I am mindful of the context of the current operating environment within HCS. In any organisation providing inpatient care there are significant inter-dependencies that affect performance. One of the most significant factors that can fundamentally change how a hospital works is the level of bed occupancy. High levels of bed occupancy, caused by large numbers of 'medically fit for discharge' patients not being able to be discharged, create pressure leading to shortages of inpatient bed capacity and ultimately challenges in admitting patients who need inpatient care.

62. Historically in Jersey inpatients who were 'medically fit for discharge' were discharged in a timely manner, which in turn created space in the hospital to admit new patients. This continuous admission and discharge of patients is referred to as 'patient flow' and is key to the smooth and efficient running of all aspects of hospital performance. In 2018 the UK National Institute for Health and Care Excellence (NICE) recommended hospitals plan to maintain bed occupancy levels below 90% for operational safety and efficiency reasons. In 2020/21 the NHS national planning guidance stated that bed occupancy levels should be reduced to a maximum of 92%.

63. Since the COVID-19 pandemic this patient flow in Jersey has been challenging with bed occupancy levels of up to 100%. Where there used to be 10 to 15 'medically fit for discharge' patients in JGH at any one time, there can now be up to 50. Patients medically fit for discharge can currently account for up to 25% of the inpatient capacity. The impact for both the patients and the healthcare system is negative, with JGH capacity and staff under greater strain. The result is that some medically ill patients who need to be admitted as 'urgent' or 'emergency' (particularly late at night) cannot always be immediately accommodated on medical wards. Instead, they are sometimes temporarily admitted to available surgical beds, which are intended for patients undergoing planned surgery. These medical 'outlying' patients will subsequently be swapped onto medical wards, with medical patients who are ready for discharged being moved onto surgical wards. This issue of patients not always being in the intended clinical areas is further compounded in JGH because of the shortage of single rooms.

64. These challenges can lead to situations where JGH has at times had a shortage of available medical beds for admission. As medical patients are being temporarily admitted into surgical beds, planned elective surgery has at times been rescheduled. These cancellations can often be at short notice, which can cause continuous reworking of ward schedules and theatre lists. If patients are admitted to beds which are not on the ward which best suits their needs, this can create additional pressures for HCS staff. As a result, patients may need to be moved

from ward to ward, to return them to their intended clinical area, which results in additional work for HCS staff and can be disorientating for patients.

65. In summary, the current inpatient bed pressures are putting all parts of HCS under stress. Developing a workforce strategy and making changes to HCS arrangements in such a complex and stressful operational environment are particularly challenging.

66. Against this backdrop of current operational challenges, I have considered the arrangements for HCS medical staff in the following six areas:

- consultant and other medical staff engagement
- the clinical management of consultants and other medical staff
- the performance management of consultants and other medical staff
- consultant and other medical staff job planning
- arrangements in respect of locum medical staff, including clinical supervision, performance management and job planning; and
- arrangements for management and oversight of the ratio of public to private patient activities.

Consultant and other medical staff engagement

67. The importance of effective engagement with clinical staff cannot be over-estimated. For example, a 2017 British Medical Association paper on '*Engagement within the NHS*' notes that good medical engagement is important and that poor medical engagement is directly linked to risks to patient safety and poor outcomes.

68. Good medical staff engagement allows medical staff to contribute actively within their normal working role to maintaining and enhancing the performance of the organisation. The consensus among almost all staff interviewed as part of my review was that medical staff engagement was at best variable and at worst, poor.

69. The 2022 HCS Divisional Business Plans all contain a section on Staff Experience and the 'Be Heard' Survey. However these appear to be focussed on implementing the basic infrastructure of staff engagement such as a checklist on communication, 'walk the floor' techniques, timetabled Care Group meetings and newsletters. The plans show that HCS is at an early stage of implementing effective engagement rather than at a stage of improving engagement.

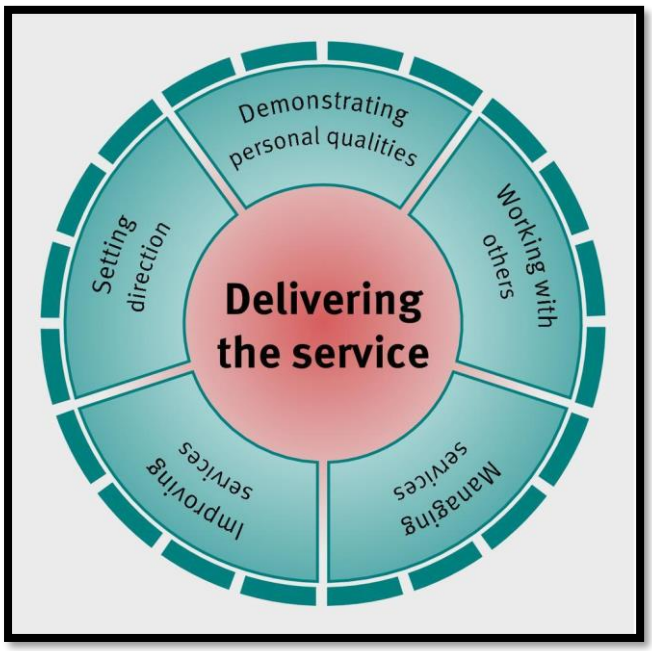
70. I understand that a 2023 'Be Heard' Survey is planned. It is extremely important that the results of that exercise and any resulting action plan to improve performance in HCS are openly and transparently communicated. Best practice would see any action plan being co-created and its delivery jointly overseen by both managers and staff group representatives.

71. To be effective, I would expect the 2023 HCS business planning process to reflect on staff engagement progress during the last year and establish a new set of improvement actions for 2023.

72. Engagement is a two-way process. Best practice is for all healthcare professionals to work together for the common goal of delivering excellence in patient care. All clinicians are leaders, which means management is not just the job of staff in management positions or the job of the relatively few clinicians who hold the formal posts of Medical Director, Associate Medical Director (Chiefs of Service) or Clinical Lead.

73. The Medical Leadership Competency Framework developed by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges, was first published in 2008. The Framework is summarised in Exhibit 3. Leadership (in its many dimensions) is a key competence of all senior clinicians and these leadership qualities can, if harnessed, be used to develop effective strategies for HCS and resolve current operational issues and tensions.

Exhibit 3: Medical Leadership Competency Framework



Source: The Medical Leadership Competency Framework developed jointly by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement

74. In my view it is essential for medical consultants in Jersey to recognise the everyday leadership roles that come with being a consultant. I consider that, if consultants recognised these consistently and if senior managers had better prioritised their initiatives to reflect the challenging operating environment in 2022 and were more skilful in managing consultants, then clinical engagement would be significantly better.

Clinical management of consultants and other medical staff

75. I have considered two dimensions of clinical management of consultants and other medical staff:

- clinical governance; and
- management of clinicians.

Clinical governance

76. Consultants are personally and professionally responsible for treatments they provide to patients. They are also personally and professionally responsible for treatments that middle grade and junior doctors give in their name and they can only discharge this responsibility by supervising these staff.

77. All clinicians interviewed as part of my review demonstrated a strong desire to provide safe, high-quality services. In addition, the general feedback from my interviews was that clinical colleagues are very supportive of each other.

78. The *Review of Health and Community Services (HCS) Clinical Governance Arrangements within Secondary Care* report (commissioned by HCS management and authored by Professor Hugo Mascie-Taylor) was published in August 2022. The Report raises a number of issues in respect of clinical governance. The Report states:

Jersey faces the challenges of a small island. (The same geography which make it so attractive). Its population is just greater than 100,000 and it is over 160 miles, by air or sea, to the United Kingdom (UK).

It is an affluent island and all the people and patients of Jersey, irrespective of their individual financial circumstances, need and deserve high quality, safe healthcare. They must be assured that this is being delivered by the publication of bench-marked clinical outcome and management information from a proactively managed accountable organisation which has adopted the systematic approaches to safety and quality seen in other industries, and in modern healthcare, across the World.

Sadly, it is not possible to conclude that this is the current situation, and the Government of Jersey, on behalf of the people of Jersey, must demand this service

from HCS and its employees, and publicly and assertively support the organisation in achieving it.

HCS must respond to the challenge by becoming an exemplar of good clinical governance, driven by openness, transparency, and internal and external accountability, as well as by a strong managed approach to systematic quality improvement.

This represents a substantial change from the ingrained attitudes and behaviours of many years, probably decades. It is and will be difficult and change may be vigorously resisted. The current non-accountable and individualistic culture, at least of some groups of staff, firmly rejects, sometimes noisily and angrily, any move in these directions, seeing them as unnecessary, interfering, and bureaucratic, and certainly not required in Jersey.

79. The Report makes 61 recommendations. I have not assessed those recommendations as part of my review. It is however in my view essential that HCS responds publicly to those recommendations and publishes an action plan to address the issues raised in the Report. Best practice would see HCS management and clinical leaders working together to co-create and agree a response and an action plan to deliver the recommendations.

Management of clinicians

80. There are significant problems in the management of clinicians within HCS. These problems were highlighted in interviews by medical consultants, other grades of medical staff and senior and middle managers.

81. Managing senior employees like medical consultants, who have significant leverage and informal power, requires well developed leadership and influencing skills.

82. There appears to be a worsening of effective working relationships between consultants and staff in senior management positions in several key areas. It is clear that the increasingly challenging system that both clinicians and staff in senior management positions find themselves working in has contributed to some of the behaviours that have led to a worsening of effective working relationships.

83. My audit interviews elicited a wide range of negative comments from clinicians reflecting on their experiences of staff in management positions managing them. Similarly, my audit interviews elicited a wide range of negative comments from staff in management positions reflecting on their experiences of managing clinicians.

Performance management of consultants and other medical staff

84. The General Medical Council (GMC) appraisal and revalidation process for individual consultants is designed to demonstrate that they are personally and professionally fit to practice. HCS has a well-established process for undertaking GMC appraisal and revalidation, with a nominated clinical lead (Responsible Officer). There is also a policy which is being updated in 2022 and evidence that the process is audited.

85. However, the appraisal process to determine an individual consultant's contribution to HCS's organisational objectives is unclear.

86. At the current time, the appraisal and performance management of medical staff in HCS are seen more as professional, rather than organisational, processes. The Job Planning policy (version 2, page 5) includes however that '*it should be noted that job planning, and appraisal are, and should remain, separate processes*'.

87. Individual consultants do not appear to be subject to formal performance management regarding their wider HCS and Government of Jersey organisational contribution. Specialties and divisions are subject to HCS performance management (for example, business plans and performance reviews). However, the performance management 'golden thread' is not visible between the specialty Clinical Lead and individual senior clinicians.

Consultant and other medical staff job planning

88. The current terms and conditions for consultant medical and dental staff were agreed in January 2005. From a best practice perspective, the overriding principle of job planning should be to apply the 2005 consultants' contract fairly and consistently.

89. The Jersey consultants' contract is however vague on key issues such as how many Supporting Professional Activities (SPAs) are allowed. SPAs are intended to be used for things such as clinical audit, continuing professional development and other training. Contracts include a range of 1.5 to 2.5 SPAs per week (equating to roughly 0.75 to 1.25 days). There is also a discrepancy in statements of where these SPAs must be worked. This lack of contractual specificity meant that when job planning was being refreshed and updated in 2022 there is a risk that consultants and other medical staff might feel that a contract renegotiation was happening at the same time as implementing job planning.

90. During 2022, HCS has been in negotiation with the Jersey Local Negotiating Committee (LNC) in respect of an updated Job Planning Policy. The Jersey LNC is made up of local trade union representatives who are nominated by the British Medical Association (BMA) and the Hospital Consultants and Specialists Association (HCSA) and will also include the BMA and HCSA regional representatives. Management is also represented. While Version 2 of the

proposed Job Planning Policy had not been formally approved by the LNC at the time of my fieldwork, I understand that it was formally approved on 8 December 2022 and sets out the tariff for SPAs.

91. Despite this lack of formal approval during 2022, job planning for middle grade and consultant staff has been proceeding. There is evidence that this fragmented approach to job planning is creating significant confusion, frustration and anger from both management and medical staff.

92. A best practice approach would have been for the following to have happened before proceeding with job planning:

- agreement between the Government, HCS executive team and clinical leaders as to the strategic clinical model that should be put in place at specialty level given the unprecedented current pressures on the system
- analysis of the impact of the agreed strategic clinical model on the strategic approach to be adopted to deploying medical staff; and
- consideration of the need for a new consultant contract and negotiation and agreement of any changes to consultants' contracts.

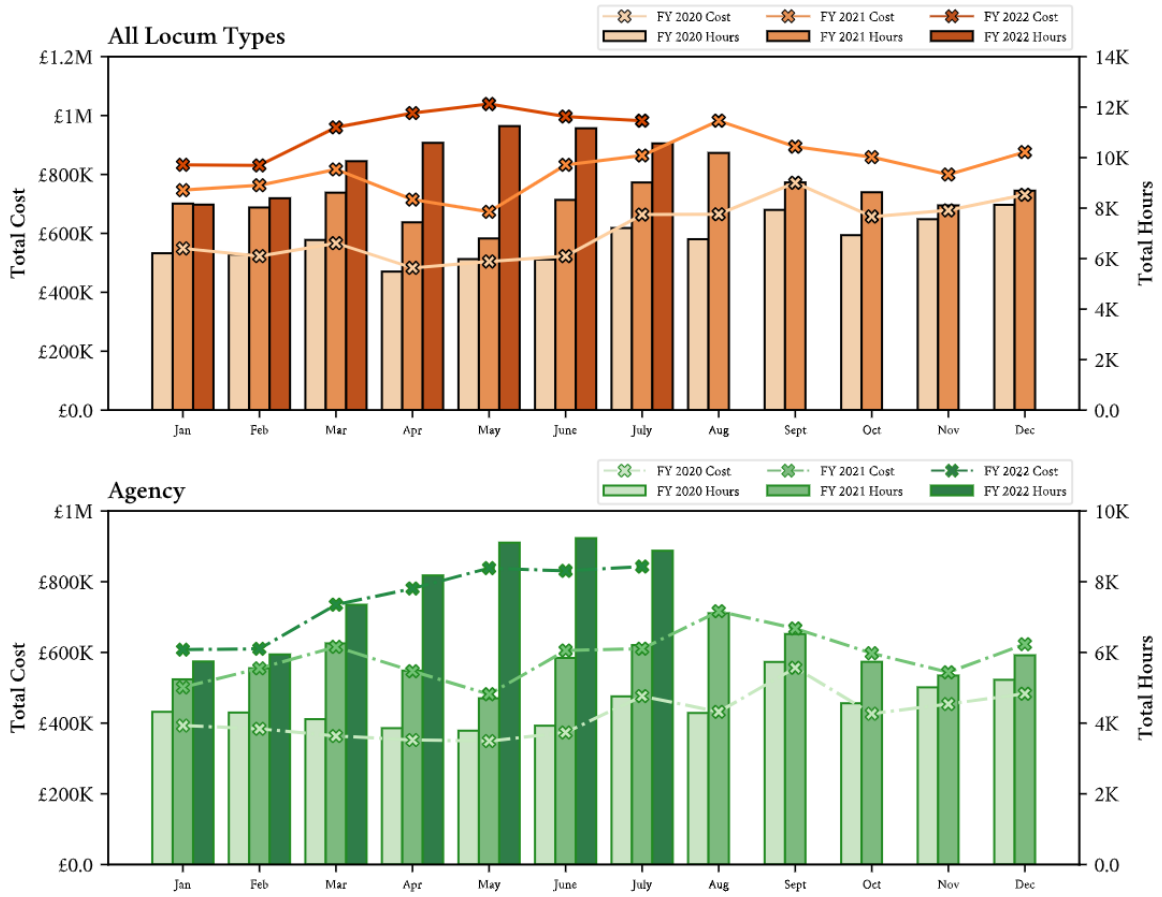
93. Instead the opposite has happened with job planning proceeding without these elements agreed or in place. Driving changes through at operational level, without a formally agreed job planning policy and without key higher-level strategic agreements in place, creates a risk of both alienating and antagonising the senior medical workforce.

Arrangements in respect of locum medical staff

94. HCS has found it increasingly hard to recruit or retain permanent staff (medical and non-medical) in what is a challenging worldwide market for health staff after the COVID-19 pandemic. There are higher levels of HCS vacancies and, in-turn, higher levels of locum and agency staff, for both medical and non-medical posts.

95. During 2022, HCS has increased its use of locum and agency staff as shown in Exhibit 4.

Exhibit 4: Use of locum and agency staff



Source: States of Jersey Management Information July 2022

96. Locum and agency doctors are provided to HCS under a framework contract with Holt Doctors which is responsible for all the necessary pre-employment background checks to ensure that these doctors are 'fit to practice'. This framework contract commenced in 2017 and is currently out to procurement.

97. The increased use of locum and agency staff is driven partly by the need to increase capacity to tackle waiting lists and partly by recruitment and retention issues within HCS. These current workforce recruitment and retention issues potentially increase the risk of:

- existing permanent staff needing to work longer hours to cover vacancies
- temporary locum and agency staff not being familiar with systems and processes, which can at times place more pressure on permanent staff
- some locum and agency staff not always being as committed to HCS as permanent staff. For example, they can contractually refuse to do shifts and on-call, they can take holidays when they want and can give very short notice periods when they leave

- reduced continuity of care to patients given the sometimes higher turnover of locum and agency staff; and
- increased day to day operational challenges.

98. In summary there are risks that need to be managed in services using higher numbers of locum and agency staff. These include the risks of increased costs and of productivity and safety risks.

99. In addition, locum and agency staff (some of whom can be longer-term appointments) get paid higher wages than permanent staff and are more likely to receive free or subsidised accommodation. When working in the same teams as permanent staff this can create tensions and demotivate permanent staff.

100. HCS is required to organise accommodation for locum and agency staff. This falls under the responsibility of the Chief Nurse and her team. Given the shortage of available accommodation this is an expensive challenge which also distracts HCS from its core business of healthcare delivery.

101. HCS does not have a formal clinical supervision policy for permanent staff and neither does it have one for locum or agency staff. The clinical supervision that does take place is dependent upon the initiative of the individual HCS consultant.

102. There is also a potential gap in the supervision of agency and locum consultants, who are not subject to structured 'line supervision' and may not be in HCS long enough for clinical audit and other forms of clinical governance to provide assurance.

103. Holt Doctors is contracted to provide doctors and check that the background paperwork is 'fit for purpose'. However, without a robust process to assure clinical supervision is operating effectively, someone 'good on paper' might still present a risk.

Private to public activities ratio management

104. Many consultants undertake private patient activity. As there is no private hospital on Jersey, inpatient private patient activity undertaken by consultants is at the JGH, while outpatient activity may take place in JGH or in external private outpatient consulting rooms.

105. The amount of private practice undertaken by a consultant is driven in part by the capacity of the consultant to undertake such activities and by the availability of the facilities from which services can be delivered.

106. The capacity of consultants to undertake private patient work in Jersey is driven in part by the HCS policies regarding on-call rotas, the Policy on Private Patients and

by a long-standing historic understanding referred to as a 'gentlemen's agreement' that 30% of a consultant's operating theatre list time could be spent on private patient work.

107. Generally on-call rotas (often one in three or one in four PAs) are not paid and instead time is given back in lieu as follows:

- one in two rota = three PAs given back in lieu a week
- one in three rota = two and a half PAs given back in lieu a week
- one in four rota = two PAs given back in lieu a week
- one in five rota = one and a half PAs given back in lieu a week
- one in six rota = one PA given back in lieu a week; and
- over one in six rota = one PA given back in lieu a week.

108. This treatment of time back in lieu in return for on-call is important, because consultants do not always get called into HCS when on on-call and the frequency depends on the specialty.

109. The result is some consultants will have two to three PAs a week that they can devote to private patient practice, without having to sleep off a disturbed night, whilst other consultants who have worked overnight will need their rest and cannot undertake private practice. As a consequence some consultants are keen to keep the current time off in lieu policy whilst others want to get paid for on-call commitments. The preference for payment or time off in lieu varies by specialty.

110. The first version of the job planning policy proposed in 2022 provided for all on-call requirements to be paid rather than allowing time off in lieu. The implementation of this policy would have had a significant impact on the ability of certain consultants to maintain their current levels of private patient work. The latest version of the job planning policy has reverted back to time off in lieu being the compensation for on-call consultants.

111. I have followed up on relevant recommendations made within my predecessor's 2017 Report on *Private Patient Income: Health and Social Services Department Follow Up*. That Report followed up on recommendations made in 2015. In summary there has been limited progress in implementing the recommendations contained in the 2017 Report. Exhibit 5 summarises the current status of those recommendations relevant to this review.

Exhibit 5: Current status of previous relevant C&AG recommendations

Recommendation	Action taken and current status	Evaluation
R2 – Ensure implementation of the Policy on Private Patients addresses relevant risks and opportunities as identified in my report	In 2020 the dedicated private patient's manager post was reassigned and there has not been a dedicated manager in place since that time. Instead, the Planned Care Lead for the Surgical Services Care Group is responsible. It was reported in interviews that operational bed pressures are forcing private planned elective surgery to be cancelled, which is impacting on both the income HCS receives and the private income consultants receive. This was further evidenced by an August 2022 HCS business case to receive an additional £2.3 million of funding to compensate for the projected loss of surgical private patient income, relating to accommodation charges and procedural charges for the main theatres and day surgery unit. During 2021 a decision was made to separate public and private operating theatre lists. However, during 2022 the private patient's ward, rather than having a planned refurbishment to attract more private income, was instead used as an elective surgical ward, meaning there is no longer a dedicated private ward in JGH	**Partially implemented** The private patients agenda was completely overtaken by the COVID-19 pandemic. Whilst operational changes were made, they have subsequently been reversed. During 2022 the pressures on JGH have made things worse.
R3 – Establish a series of KPIs to evaluate the contribution and impact of key aspects of the Policy	A series of KPIs in respect of private patient activity and income is not in place. High quality management information is crucial to support HCS in making decisions regarding private practice.	**Not implemented**
R5 – Plan and implement a proportionate programme of audit of both cost and activity information to support future enhancements to costing across HSSD	The private patients charging function has been reduced since 2017. The Person Level Information and Costing System (PLICS) is used to calculate private patients charges. However the PLICS team was reassigned during 2020 and the last PLICS data is based on the 2020 information. Private patient charges have not changed since that date and are now out of date. For example, most private work is now done on the weekend at premium rates of pay and the tariff does not reflect this.	**Not implemented**

Recommendation	Action taken and current status	Evaluation
	An Income Supervisor has been appointed recently with the remit of developing the private patients income arrangements. This is however currently focussing on basic operational procedures rather than strategic development and information analysis.	
R6 – Agree an overhead apportionment framework applicable to all costing exercises including those supporting Private Patient Income, the Medium-Term Financial Plan and the annual budget.	This has not been taken forward.	**Not implemented**
R7 – Establish and regularly report financial KPIs which clearly demonstrate the link between current performance and business objectives in a way which enables 'at a glance' understanding of the position.	There continues to be management financial reporting on private patients income. However a series of KPIs has not been developed.	**Not implemented**
R8 – Produce a longer-term plan for private patient business that is fully integrated with other planning including the 'Future Hospital' project, workforce planning and risk management.	The HCS Surgical Services Care Group Business Plan for 2022 included an objective to review and provide a comprehensive Private Patients Service vision to increase activity and revenue. There is however a shortfall against planned income for 2022 and a longer-term plan and strategy are not in place.	**Not implemented**

Recommendation	Action taken and current status	Evaluation
R9 – Establish arrangements, including KPIs, analysis and reporting mechanisms, to assess compliance with roles and responsibilities as set out in the Policy on Private Patients.	As noted above, a series of KPIs for private patient activity and income has not been established. While a Policy on Private Patients exists, KPIs and compliance mechanisms have not been established.	**Not implemented**
R10 – Establish a framework to evaluate the effectiveness of the Private Patient Management Committee (PPMC).	The PPMC has not met in 2022 and no framework has been established.	**Not implemented**
R11 – Document and implement arrangements to enable the Health and Social Services Department (HSSD) to monitor compliance with standards for managing private work alongside public work, including against Job Plans.	The recording of public and private work has not been developed. As I have set out, the job planning process is not proceeding well. Private and public theatre operating lists have been separated in 2021. However, the change of use of the dedicated private patients ward (Sorel) into a public elective surgical ward in 2022, means that there is no longer a separate dedicated private patients ward in JGH	**Not implemented**

Source: Jersey Audit Office analysis

112. While a Policy on Private Patients exists, the absence of a Government private patient strategy setting out clearly agreed parameters, management information and KPIs regarding private patient activity, makes implementation of the Policy difficult in practice.

Recommendations

R9 Implement a specific Organisational Development programme to improve the current variable levels of medical staff engagement. In doing so, consider whether the programme would benefit from external facilitation and ensure that the programme includes senior clinicians as well as senior managers.

R10 Ensure that the HCS 2023 Business Plan continues to include actions to enhance and improve staff engagement and that the HCS Business Plan for 2024 takes into the results of the 2023 Government "Be Heard" survey.

R11 Review the relationship between the well-established GMC appraisal and revalidation process which is aimed at the individual's personal development and the wider role of performance management in terms of how an individual contributes to HCS's overall success.

R12 Consider whether there is a need to renegotiate the 2005 Jersey medical and dental consultants' contract prior to implementation of the job planning policy. Pause job planning while this is being considered.

R13 Review the arrangements for the organisation of accommodation of locum and agency staff and consider who is best placed to manage this.

R14 Include in the future workforce strategy targets to minimise the use of locum and agency staff and outline actions to achieve and maintain the use at a low level.

R15 Urgently agree and implement a formal HCS clinical supervision policy. This should cover medical and non-medical professional clinical staff, including locum and agency staff.

R16 Ensure that the new medical agency contract requires all locum and agency staff to engage proactively in HCS clinical supervision and the wider clinical governance systems.

R17 Ensure that appropriate arrangements are in place to provide assurance on the clinical practice of locum consultants during the time they are working for HCS.

R18 Revisit the current approach for compensating for on-call and consider a flexible, mixed model of either time back in lieu or payment, depending upon the specialty and grade of staff. This approach should seek to provide more flexibility for both consultant and middle grade doctors but at the same time protect capacity for the delivery of public work.

R19 Establish arrangements to monitor implementation of and compliance with the private patients strategy when it is published.

R20 Implement a comprehensive suite of management information to monitor private patient activity and income against standards, targets and tolerances.

R21 Update the Person Level Information and Costing System (PLICS) and the tariff used for private patient charges. In doing so, agree and implement an overhead apportionment framework to be applied to private patient charges.

Work Planned that should be Prioritised

P2 Publish a formal response and action plan to the recommendations made in the *Review of Health and Community Services (HCS) Clinical Governance Arrangements within Secondary Care* Report published in August 2022.

Appendix One

Audit Approach

The review approach included the following key elements:

- a review of relevant documentation (outlined below)
- engagement with the medical staff committee; and
- interviews with clinicians and key officers.

The documents reviewed included:

- Developing a Strategic Workforce Plan for Jersey, June 2021
- HCS Board Papers
- HCS business plans (including divisional plans)
- HCS Our People Strategy, Draft
- HCS Workforce Planning presentations
- Independent Review of Adult Mental Health Services in Jersey, October 2021
- Job Planning Policy, Drafts
- Management information packs
- Medical Appraisal and Revalidation Policy, Final Draft
- Peer Review of Jersey Critical Care Unit, July 2022
- People and Organisational Development Committee papers
- Policy on Private Patients, Jersey General Hospital, March 2017
- Review of Health and Community Services (HCS) Clinical Governance Arrangements within Secondary Care, August 2022
- Review of Maternity Services, Health and Social Security Scrutiny Panel, July 2021
- Statement of Terms and Conditions of Employment (Junior Doctor in Training Contract)
- States of Jersey Health and Community Services, Theatre Service Review, June 2021

- States of Jersey Skills Strategy 2017-2022; and
- Terms and Conditions of Service Consultant Medical and Dental Staff.

The following people contributed information through interviews or by correspondence:

- Associate Director of People, HCS
- Associate Medical Director Prevention, Primary Care and Interim Associate Medical Director Medicine
- Associate Medical Director Surgery
- Associate Medical Director Woman, Children and Family services
- British Medical Association Regional Officer
- Chief Executive
- Chief Nurse
- Clinical Lead Anaesthetics and Theatres
- Clinical Lead Department of Ophthalmology
- Clinical Lead Ear, Nose and Throat
- Clinical Lead Emergency Medicine
- Clinical Lead General Surgery
- Clinical Lead Obstetrics and Gynaecology
- Clinical Lead Psychiatry
- Clinical Lead Radiology
- Clinical Lead Urology
- Consultant Anaesthetist
- Consultant Cardiologist
- Consultant in Anaesthesia and Intensive Care and past Medical Staff Committee (MSC) chair
- Consultant in Emergency Medicine

- Consultant in Emergency Medicine and General Medical Council Responsible Officer
- Consultant Orthopaedic Surgeon
- Consultant Paediatrician and Local Negotiating Committee Chair
- Consultant Radiologist and Director of Post Graduate Medical Education
- Consultant Radiologist and past MSC Chair
- Consultant Surgeon (colorectal) and current MSC Chair
- Director General HCS
- Director of Clinical Services
- Director of Mental Health Services and Adult Social Care
- Finance Business Partner for HCS
- Foundation Year 1 Doctor
- General Manager, Medical services
- General Manager, Surgical services
- General Manager, Women, Children and Family services
- Group Director of People and Corporate services
- Group Medical Director
- Head of Children's Mental Health and Wellbeing service
- Head of Medical staffing
- Hospital Consultants and Specialists Association (HCSA Regional Officer)
- HR Business Partner medical staffing
- Income Team supervisor (Treasury and Exchequer Department)
- Legal services manager
- Medical staffing officer
- Specialty and Associate Specialist (SAS) committee Chair

The fieldwork was carried out by affiliates working for the Comptroller and Auditor General.

Appendix Two

Summary of Recommendations and Work Planned that should be Prioritised

Recommendations

R1 Establish a Project Board to oversee the development of the HCS Our People Strategy and the HCS Workforce Strategy. In doing so ensure that:

- the membership of the Board enables appropriate oversight and appropriate clinical engagement; and
- appropriate formal project management and governance disciplines are implemented.

R2 Enhance the engagement at specialty level in the development of the HCS Workforce Strategy. In doing so, ensure that there is an agreed way forward for future clinical operating models and medical staffing models at specialty level.

R3 Clarify the planning assumptions that should underpin the HCS Workforce Strategy in respect of the future care model and the Our Hospital programme. Continue to review these planning assumptions as decisions are made with respect to the future care model and the Our Hospital programme.

R4 Ensure that the HCS Workforce Strategy provides clarity as to the future planned management structure of HCS.

R5 Review and, where possible and appropriate, negotiate a harmonisation of the terms and conditions of staff working in HCS. In doing so, seek to ensure the availability of the right workforce on a 24 hour, 7 day basis to support the effective delivery of services by HCS.

R6 Review the arrangements for the funding of clinical negligence insurance to ensure that they match the objectives of future clinical models and the future private patient strategy.

R7 Develop, publish and implement a Government of Jersey Private Patient Strategy.

R8 Ensure that the wider HR service, which is currently spread across three teams, is co-ordinated and that there is sufficient specialist HR and finance support within the team developing the HCS Workforce Strategy.

R9 Implement a specific Organisational Development programme to improve the current variable levels of medical staff engagement. In doing so, consider whether

the programme would benefit from external facilitation and ensure that the programme includes senior clinicians as well as senior managers.

R10 Ensure that the HCS 2023 Business Plan continues to include actions to enhance and improve staff engagement and that the HCS Business Plan for 2024 takes into the results of the 2023 Government "Be Heard" survey.

R11 Review the relationship between the well-established GMC appraisal and revalidation process which is aimed at the individual's personal development and the wider role of performance management in terms of how an individual contributes to HCS's overall success.

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R20 Implement a comprehensive suite of management information to monitor private patient activity and income against standards, targets and tolerances.

R21 Update the Person Level Information and Costing System (PLICS) and the tariff used for private patient charges. In doing so, agree and implement an overhead apportionment framework to be applied to private patient charges.

Work Planned that should be Prioritised

P1 Finalise the HCS Our People Strategy taking account of the recommendations made in the *Review of Health and Community Services (HCS) Clinical Governance Arrangements within Secondary Care* report published in August 2022.

P2 Publish a formal response and action plan to the recommendations made in the *Review of Health and Community Services (HCS) Clinical Governance Arrangements within Secondary Care* Report published in August 2022.

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