

King Edward VII Memorial Hospital

Falkland Islands Government



Health & Social Services

Departmental Business Plan

2010/14

Health & Social Services Business Plan

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1. Introduction & Background

The Health and Social Services department provide a wide ranging service to support the health and well-being of the population of the Falkland Islands. The health and dental services are all based in the King Edward VII Memorial Hospital (KEMH), while social services are provided from elsewhere in Stanley.

The three main services which the Health and Social Services Department provide to the population include:

- Medical Services
- Dental Services
- Social Services

During a lifetime any member of the community may seek support from the Health and Social Services, and this is made available on an individual basis. The support offered may be a simple intervention to multiple and complex issues requiring a multi agency plan that is developed on a case by case basis.

Section 5 of the Falkland Islands Plan states that the Health and Social Services Department will “Promote and maintain a healthy and fit society” by:

“Meeting the expectations and demands for high quality health and social services is an ongoing challenge in a small community. We will promote a healthy and fit society; care for the unwell, the elderly and the disadvantages within the resources available”

1.1 Period of the Plan

This business plan is set to run from 2011-15 but will be updated annually in a cycle to support the budgetary process.

1.2 Brief overview of the service

i. Purpose

The Health and Social Services are there to serve three broad groups of people:

- a) The population of approximately 3,500 *Falkland Island residents*, offering care from the cradle to the grave.
- b) Secondary care (that is after referral from the primary health care givers) for the *military forces* serving in the Falklands, their dependents and contractors and families.
- c) Health care to *visitors of the Islands*, (2009-10 season saw up to 48,000 tourists mostly on cruise ships) and international fishing fleets who come from the high seas as well as fishing in the Falkland water

ii. Employees

There are c. 98 employees for the provision of these highly complex services. The apparently simplest work has to be done with staff who are motivated to a high degree as they face the challenges of the general public who are at their most vulnerable. This requires treating the public with confidentiality, high standards of infection control, great integrity and professional skill.

iii. Key Stakeholders

- Whilst it is possible to identify stakeholders, it should be noted that with the Health and Social Services Department, everyone may and probably will have contact with us during their lifetime.
- **The population of the Falklands, including Elected Members** are the major stakeholders of the health and social services. Health and Social Services provide care from the cradle to the grave. This requires all-encompassing service provision to meet the needs of a population that is demographically similar to the population in any larger country. The customers therefore tend to have contact with us over issues that are of a personal nature that make the individual feel very vulnerable.
- The **staff**, without whom the health and social services would not be able to offer the quality service that is available. The organisation chart (*next page*) depicts the wide range of services offered over the full 24 hour a day, 7 days a week but does not reflect the commitment of staff who work at providing this quality care. In few other health and social service departments would staff be expected to embrace the challenges of working across a broad range of areas.
- The nature and complexity of the work carried out by the Health and Social Services Department means that there is always a close working relationship maintained with customers from **other departments within the Falkland Islands Government** (FIG) most commonly Education, Police, Fire Service, Housing, Treasury, Human Resources and PWD to name but a few. Outside of FIG are the Fishing Agencies, Military, overseas hospitals and social services especially in the United Kingdom or Chile.
- The **Ministry of Defence** (MoD) - with which there is a Memorandum of Understanding (MoU) for which there is a contribution made by the MoD towards the running costs of the King Edward VII Memorial Hospital (KEMH) based on an activity formula agreed in 2007. The MoU defines the level of service that the MoD require.
- **Third-party contractors**, such as Island Health Services who provide the Surgeon and Anaesthetist services, and X-change who are contracted to provide the radiography services to the Islands.
- **External auditors and reviewers**. These assist the department in its work and include the anaesthetic, surgical, microbiology and dental advisors appointed to assess the quality of service offered by these departments. There is an authorised person to review the decontamination and sterilisation service offered, and the radiation protection agency visits regularly.

iv. Financial Profile

The 09/10 actual operating performance for the departments was:

Total Revenue:	<u>£1,503,340</u>
Health Service Expenditure	£5,627,543
Dental Service Expenditure	£260,678
Social Service Expenditure	£706,009
Total	<u>£6,594,230</u>

The cost is, based on 5,000 population, therefore approximately £1,319 per head of population which compares favourably with for instance the Shetlands where it is £1,632 per head of population. It should be noted that the Shetlands are not faced with the significant airfare costs to transfer patients for more definitive care.

Health expenditure as a proportion of GDP, the Falklands compare well when benchmarked internationally. In the decade up till 2008, an average of 6% of GDP was expended on Healthcare. This compares to USA at 17.6% (2007), Malta at 9.7%, Australia at 9.5%, UK at 7.7% and Chile at 6.4%. Most developed nations proportion of GDP to be spent on HC is forecast to increase rapidly.

v. Key drivers

At present there is a variety of legislation and a large number of varying policies imposed on the Health and Social Services department, a selection of the key ones of these are:

- Medical Practitioners, Midwives and Dentists Ordinance (Cap.45) Vol 1 p430 (27 June 1914)
- Medicines Ordinance 2006 (13/06) 2006 Supp 9 (Not yet in force)
- Mental Health Ordinance 1987 (17/87) 1987 p131 (1 July 1992)
- Mental Health Ordinance 2010 (7/2010) 2010 Supp 8 (Not yet in force)
- Misuse of Drugs Ordinance 1987 (16/87) 1987 p 119 (31 March 1989)
- Infectious Diseases Ordinance 2003 (24/03 2004 Supp 1 (22 January 2004)
- Children Ordinance 1994 (28/94 1994 Supp 31 (1 January 1995)
- Access to Health Records Ordinance 1995 (19/95) 1995 Supp 35 (1 January 1996)
- Sexual Offences Ordinance 2005 (12/05) 2005 Supp 13 (10 June 2005)
- Public Health Ordinance (Cap. 4) Vol 1 p 482 (generally from 11 August 1994 – but some provisions have different commencement date i.e. amending provisions

In addition to the Ordinances above there is an active Health and Medical Services Committee (HMSC) with membership appointed by Executive Council (ExCo). Current membership consists of the following:

1. Chairperson (Councillor with Health portfolio)
2. Councillor in support
3. Councillor serving on Executive Council
4. Director of Health and Education
5. Chief Medical Officer
6. Senior Medical Officer from Mount Pleasant
7. Medical Department Administrator
8. A lay member
9. A lay member.

All strategic and policy decisions are referred to HMSC before they can be accepted or transferred to the process for a decision from ExCo.

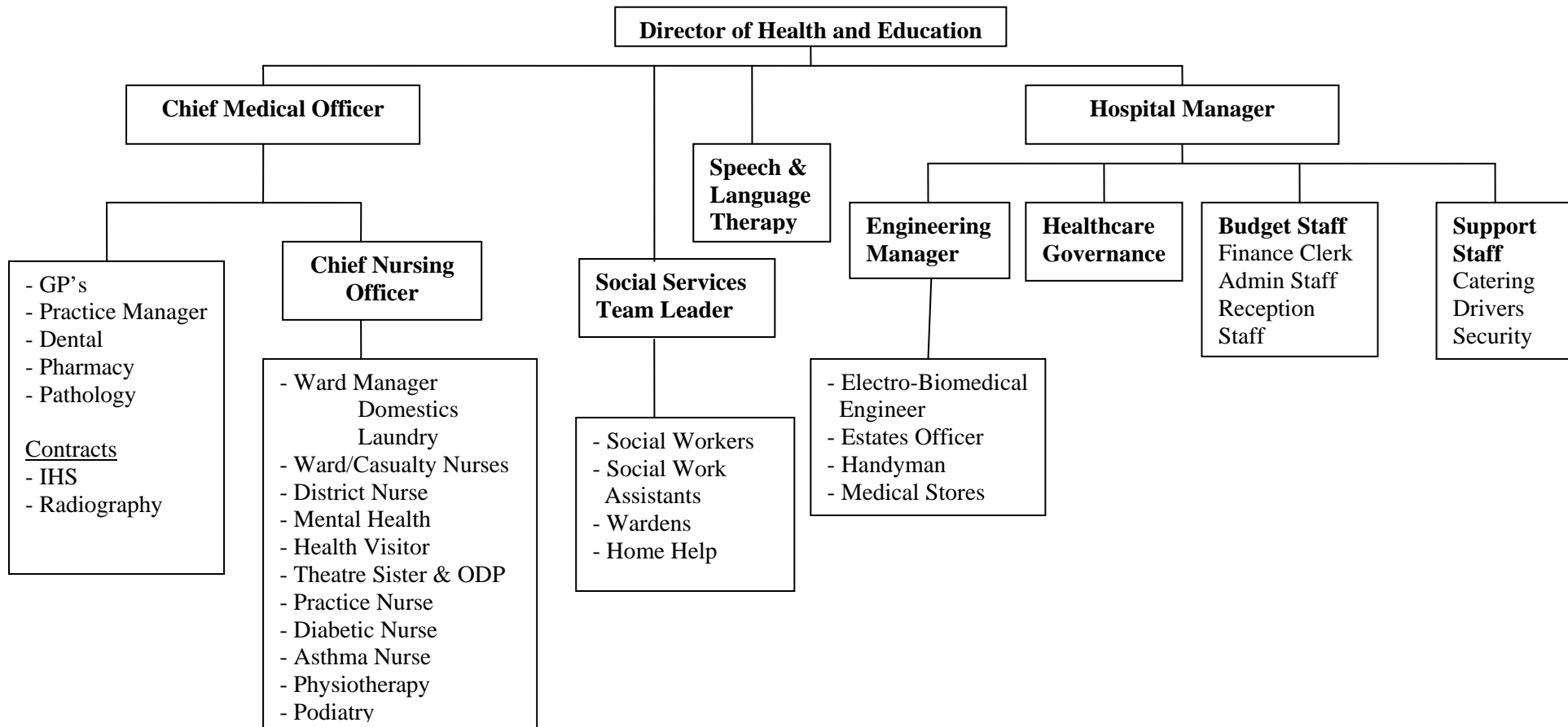
In addition to the above, a cost sharing committee meets, to discuss the Memorandum of Understanding between the FIG and the MOD, membership of this committee includes:

1. Director of Health and Education
2. Chief Medical Officer
3. Administrator Health and Social Services
4. Senior Medical Officer
5. Command Secretary
6. Practice Manager
7. Financial Manager MoD

The Health and Social Services Department is also subject to other key drivers and these include:

- Public opinion and political guidance
- Professional Bodies, expectations of those who have registered with them to act within their relevant codes of professional conduct and associated frameworks.
- World wide developments of health and social services where the ability to treat, manage and cure ever more complex diseases is ever present and often relate to agreed clinical standards of excellence.

Organisation Chart: 2011 Structure



1.3 Scope of the Service

The scope of the Health and Social Services department includes:

Dentistry Two dentists provide the services for dentistry in the Islands supported by the dental nurses. To ensure consistency in the provision of care a Dental Advisor has recently been appointed.

Medical This is primarily provided by General Practitioners (GPs) with an extended role including obstetrics, ophthalmology, endoscopic screening, casualty and inpatient medical services. The GP's are registered in the United Kingdom with the General Medical Council; all undertake annual accreditation by the Independent Doctors Forum. Island Health Services are currently contracted to provide the surgical and anaesthetic services. The Falkland Islands Government have appointed Surgical and Anaesthetic Advisors to ensure the standard of surgical and anaesthetic care is effective.

Pharmacy There is one pharmacy available for the islands. There is an over-the-counter service along with dispensing from prescriptions, In-patient care, pharmaceutical management along with maintaining 'camp medical chests' at specified locations throughout the islands.

Administration Supports the entire health service with administration, medical secretarial support, budgetary management including invoicing, payments, cash flow, co-ordination and arrangements for medical treatment overseas, reception and maintenance of filing and medical records.

Security and Driving Provide for the security of the hospital environment, driving in response to emergency calls as well as routine transport.

Nursing Provide nursing care in all settings and to all patients and clients including practice nursing, casualty and ambulance as well as response to emergencies at sea via boat, and in camp, theatre where there are Operating Department Practitioners as well as a theatre nursing sister, inpatient care including all aspects of admission, acute medical and surgical, intensive, cardiac and high dependency, acute psychiatric and serious and enduring psychiatric ill health, midwifery, paediatrics, planned surgery and medical admissions, respite care and long term elderly residential care, district nursing and community psychiatric nursing, health visiting.

Housekeeping With a dedicated staff who have worked to ensure that the hospital is free from Hospital Acquired Infections and including laundry services.

Catering Provide meals for in patients, specialist diets, meals on wheels in Stanley, staff, sheltered housing and the prisoners housed at the police station.

Estates and Engineering Manage the estate and bio-medical equipment maintenance within the hospital.

Stores Maintain adequate levels of medical stores to ensure that the department is able to meet the needs of its customers.

Pathology Laboratory Provide the inpatient testing as well as primary care, co-ordinating the referral overseas for testing not available in the Islands, public health and veterinary referred cases.

Physiotherapy This is shared with the military on a 50:50 cost sharing basis, with the staff member working in Stanley for three days a week and Mount Pleasant Medical Centre two days per week.

Speech and Language Therapy Work with adults although are mostly focused with children to improve communication skills including hearing, speech, language, swallowing and eating as well as raising awareness to ensure that the community engage in communication with all.

Healthcare Governance & Development Facilitator Leads on healthcare governance as well as providing clinical development coordination of in-service training as required by staff and management. Responsibilities include Chairing the Policies, Procedures and Protocols Committee and the Incident Reporting and Complaints Committees.

Social Services Includes safeguarding children, child protection, working with children in need, vulnerable adults, housing, sheltered housing, welfare benefits and fostering arrangements.

2. Vision, Mission & Values

Having provided an overview of the health and social services department, this next section lays out what exactly the service aims to achieve.

The Health Statement within the Islands Plan 2010-15 states that;

“Meeting the expectations and demands for high quality health and social services is an ongoing challenge in a small community. We will promote a healthy and fit society; care for the unwell, the elderly and the disadvantages within the resources available”

Feeding out of this aim comes firstly the Health Vision, and then the Health Mission.

The Health Vision

“To provide a service that empowers individuals, families and the community to achieve optimal lifelong well-being”

The Health Mission

“To provide high quality, cost effective health and social services which address the identified needs of the populations we serve, in order to preserve life, treat illness and promote lifelong well-being within the resources available”

In order to work towards the Health and Social Services Vision and Mission it is our intention that:

- The community will have an understanding and ownership of health and health issues.
- Individuals will take primary responsibility for managing their own health.
- Families and individuals will have an understanding of the risks posed by their own behaviour and by others in society.
- Parents will have the skills and knowledge to protect their children and will take responsibility for their health and well-being.
- We will provide a preventative, community-orientated service whilst protecting the essential secondary care services that people require when most in need.
- There will be a range of joined-up services tailored to the needs of children and young people.
- There will be a range of services and strategies across government that promote the meaningful existence of the most vulnerable people in our community, particularly those with mental health, learning or physical disabilities.
- It will be socially and financially acceptable for vulnerable people to stay at home, if they so choose, cared for by their relatives. They will be supported by a range of community services including day care opportunities and activities.
- We will articulate a clear set of locally devised and owned standards to which we work.

The Health and Social Services **headline values** are:

<u>Respect and compassion</u>	We will be friendly, supportive, compassionate, caring, kind, thoughtful, positive and helpful whilst also taking responsibility and being approachable.
<u>Reliability, accessibility and responsiveness</u>	We will try to do what we say we are going to do in a consistent and timely manner
<u>Equity</u>	We will take action to ensure that services provided are based on needs and entitlements not on age, sex or sexual orientation, colour, race or creed etc.
<u>Non judgemental</u>	We will treat people in accordance with their needs and not discriminate on any grounds.
<u>Confidentiality</u>	We will only use person identifiable information for the purposes of providing health and or social care unless we have the persons' explicit consent, some other legal basis or other robust justification to do so.
<u>Openness and honesty</u>	We will be open and honest about our policies, our standards and our decisions and publish information on our services, policies, procedures, standards, decision-making criteria and performance where appropriate
<u>Empowering</u>	We will endeavour to provide services that are client-centred and will involve patients/clients in the planning and delivery of their care/case; we will explain treatments/processes and keep them informed of progress
<u>Partnership and team working</u>	We will work as a team and recognise and respect the contribution of every team member whilst also working effectively with outside agencies in order to promote quality outcomes for patient/client contacts
<u>Safety</u>	We will maintain and develop standards for our physical environment, including maintenance of equipment, cleanliness, infection control and we will treat each other with respect.
<u>Learning and Innovation</u>	We will undertake regular, systematic performance development reviews with all staff and seek ways to meet the learning needs of teams and individuals. We will not blame but seek to understand.
<u>Pride</u>	We will take pride in doing the best job we can within the resources available.

3 Where is the service currently?

3.1 Baseline assessment of service

The last external clinical governance audit in October 2010, carried out by MoD inspectors, noted that the health and social services was achieving a gold standard of care at the bedside and needed to improve on recording and auditing of services. Their main recommendations include the following:

- ❖ A corporate risk management strategy and process should be developed to capture, mitigate and manage risks (see section 6).
- ❖ A strategy for the management of healthcare records in alignment with current legislation and standards should be developed.
- ❖ An organisation-wide patient safety incident reporting process should be established. Personnel that would support the incident reporting process by undergoing root cause analysis training should be identified.
- ❖ A strategy and mechanism should be developed that sets out which UK clinical guidelines (NICE) and other guidance are going to be used across the Organisation, and set out how this will be disseminated.
- ❖ A strategy for medicines management across the organisation should be developed. This should set out which legislation and standards should be used, in order that policy can be created, and performance assessed.
- ❖ A strategy should be developed on the requirements for registration with a professional body and this should include an assessment of the impact on individual professionals and services.
- ❖ Annual appraisals for all staff should be instigated in alignment with FIG policy.
- ❖ A strategy for developing inter-professional working and training for the holistic care of the patient should be developed.
- ❖ A complaints manager should be identified, with a complaints policy to then be implemented.
- ❖ The organisation should consider establishing a supportive and fair-blame culture where staff feel able to raise concerns.

These key audit recommendations have been formulated into a plan of action that has been agreed with the MoD Inspectors. These major actions along with a number of others are detailed in section 5 of this paper.

The Falkland Island Government internal financial audit revealed a need to improve financial management and budgetary control, something that continues to be actively pursued, and is also detailed in the action plan at the end of this paper.

3.2 How do we know if the service is meeting its objectives?

With a health service within a small community, feedback is relatively quick and constant both through formal and informal channels.

In addition to feedback via political representatives on behalf of their constituents, annual external and internal audits are performed across the healthcare service, as well as on a number of specific areas (e.g. pharmacy, dental etc). Regular and formal feedback is also received from other stakeholders such as the MoD.

In addition to the above, specifically for in-patients - patient satisfaction surveys are carried out on a monthly basis. These look at:

- Were the staff friendly
- Were you treated with dignity and respect
- Were you involved in treatment decisions
- Were you given consistent advice/information
- Were you given enough privacy when discussing your treatment/condition
- How would you rate the cleanliness of the ward/bathroom
- How would you rate the food
- Overall how would you rate your stay
- Was it quiet enough at night for you to sleep (only asked for overnight stays)
- How would you rate the menu choice (only asked for overnight stays)

Ratings for 'overall how would you rate your stay' are 100% good or very good.

3.3 Key achievements and outcomes

- a. The provision of National Vocational Qualifications (NVQ's) has improved the standards of care offered by the auxiliary nurses.
- b. Improved multiagency working as a result of the review of the Falklands compliance with the convention on the rights of the child has led to good working relationships focussing on the development of personal health and social education being presented to the Falkland Islands Community School from health, social services and police as well as the tutors of the year groups.
- c. Investment in equipment has led to laparoscopic cholecystectomies being offered in the Islands as well as increased effectiveness at the bowel screening programme which along with a high level training course undertaken by Dr Elsby has reduced the bowel cancer in the Islands.
- d. The Mental Health Ordinance has been agreed by Legislative Assembly and came into force in November 2010.
- e. The MoD undertook an audit in late 2010 looking at healthcare governance, with a number of actions noted, but they the audit stated that they were "impressed with the delivery of patient centred healthcare, by a dedicated and talented team of staff with a vast amount of skills, knowledge and experience."

4. How does the service compare?

4.1 To other service providers

It is difficult to find another Health and Social Service Department to realistically compare the services that are offered. The MoD clinical audit provides a review and comparison of clinical services against services offered in the UK. The internal and external auditors have reviewed financial strengths and weaknesses in the department. For instance the number of virements were over twice as many as other departments indicating that we are not strong at anticipating the areas of financial pressure.

4.2 To where the service needs to be?

In order to identify where the medical department needs to be in the next five years, a SWOT analysis has been performed. The results of this work is summarised below:

<p><u>Strengths</u></p> <ul style="list-style-type: none"> • Experienced and knowledgeable staff • Ability to manage and care for patients with diverse and complex needs • Multi agency involvement in patient care and treatment • Availability of specialist expertise • Training and development programme • Healthcare Governance - Improving Standards • Political support from Members of Legislative Assembly (MLAs) • Close working links with other FI Government departments – Police, Fire, Education • Re-structuring of senior management • Disease surveillance register • Vulnerable peoples’ strategy being produced • Mental Health Ordinance 	<p><u>Weaknesses</u></p> <ul style="list-style-type: none"> • Limited budget – financial implications • IT systems incompatibility • Communication technology • Recruitment and retention of personnel • Delivery of training and development due to staffing • Importation of essential stores and equipment • Documentation – Audit trail of patient pathway • Medicine management • Core competencies for staff • Annual staff appraisals • Policies/procedures/protocols in line with evidence based practice
<p><u>Opportunities</u></p> <ul style="list-style-type: none"> • Development in IT systems • Joint ventures with other health service providers which include <ul style="list-style-type: none"> - MoD - X-Ray - Pharmacy - Pathology - Surgeon and anaesthetist • Improving services to accommodate oil exploration personnel • Global influences • Diversity of population 	<p><u>Threats</u></p> <ul style="list-style-type: none"> • Unrealistic political demands e.g. legislative • Economic – reliant on fisheries and possible oil revenue – financial constraints • Material increase in population, especially the elderly • Attitudes/aspirations and expectations of service users • Geographical – importation of resources – rural population • Seasonal – tourism/fishing • New technology and innovation • Increased standards of performance expected from professional registration bodies who look to more specialised working than is feasible in the Islands, • Development and improvements of health and social expectation outcomes • Continuity of service with new directors and department heads as well as staff.

This SWOT analysis has been utilised to inform the next section which contains the action plans for service enhancement and improvement.

5. How do we get to where we need to be?

5.1 Key Developmental Objectives

	Objective	Task-Action	Lead	Targeted Output	Targeted Outcome	Resources	Timescales/Milestones
1	A corporate risk management strategy and process to be developed to capture, mitigate and manage risks.	To construct and agree a risk-management strategy for Health & Social Services.	DHE	To have an agreed list of key risks, with mitigating actions where possible and a clearly identified responsible lead. To have in place a 'Risk Panel' for the department which meets quarterly to review and update risks.	To have identified and clearly articulated major risks across the health service to ensure mitigation is in place where possible, and where not, that relevant parties (e.g. CMT and ExCo) have been made aware.	Health Senior Management Team time. Potential budget implications stemming from mitigating actions.	System in place by December 2010. Ongoing quarterly Risk Panel review meetings.
2	A strategy for the management of healthcare records in alignment with current legislation and standards should be developed.	To review all relevant legislation and, where gaps exist, to identify relevant overseas legislation to apply to the management of records.	DHE / HGF	A record system that is fully compliant with legislative standards and best practice in areas not legislated for.	To have policies and procedures for management of healthcare records in place, and to ensure that they are adhered to.	Policies, Procedures, Protocols and Guidelines Committee time.	December 2010.
3	An Organisation-wide patient safety incident reporting process to be established.	Personnel that would support the incident reporting process by undergoing root cause analysis training should be identified.	HGF	A method to track and analyse trends in PSIRs based on a recognised coding method should be established.	An overarching policy on the management of safety alerts across the Organisation should be established.	Healthcare Governance Facilitator time, and potentially c. £2,000 for IT software.	Target completion date for all strands is June 2011.

4	A strategy for medicines management across the organisation should be developed. This should set out which legislation and standards should be used, in order that policy can be created, and performance assessed.	For a cross-section of departments to work together on putting in place an up-to-date and comprehensive Medicines Management Strategy for the Health Service.	CMO/ CNO/ HGF/ MEM / Phar.	Consideration in establishing a medicines management committee should be made as part of the overarching strategy.	A clear and agreed medicines strategy that is available across the KEMH and clearly references overseas legislation or guidance where necessary. Also, an agreed review timeline.	Senior Management Team time and incidental expenses for purchase of relevant guidance/book etc.	December 2011.
5	Arrangements to be made for the safe disposal of hazardous waste being stored in pharmacy and the labs. A strategy and standards for the safe disposal and destruction of clinical waste which includes checks on compliance to be developed.	To agree a waste-management strategy, especially for medical and clinical waste, that meets best practice and legislation, as is practical in the Islands.	DHE / MEM	A workable waste disposal strategy that offers a sustainable system for the future. Input from all relevant stakeholders across FIG and also the private sector.	A workable waste disposal strategy that offers a sustainable system for the future.	Will require input from across FIG and likely costs will be involved once strategy is agreed.	June 2011.
6	Review the nursing structure to ensure that it is line with the Falkland Island requirements and offers value for money.	Establish nursing competencies Review and update job descriptions and have them re-evaluated Establish new structure as required.	CNO / DHE	Establish nursing competencies Review and update job descriptions and have them re-evaluated CPD included as mandatory for permanent employees	Medium to long-term strategy in place for nursing structure and competencies including any CPD requirements.	Management time for review	June 2011.

5.2 Key Service Level Objectives

	Key Process	Key Performance Indicator	Lead Person	Baseline	2010/11 Target	2011/12 Target	2012/13 Target	2013/14 Target	2014/15 Target
1	Treating and caring for people with acute needs	Satisfaction with services received (patients and clients) and major customers (MoD)	DHS	Over 75% find service to be fair or better	80% find the service to be fair or better	85% find the service to be fair or better	85% find the service to be fair or better in all areas	75% find the service to be good or better	80% find the service to be good or better
2	Safeguarding and promoting the welfare of vulnerable people	Vulnerable in society of all ages are socially included and able to access meaningful activities, services that meet their needs, education or employment	DHS	There is an employment programme with supported placements which could be extended		Vulnerable people's strategy accepted by ExCo. Review how care delivered to over 75s and agree a protocol for consultations /preventative care	70% of people identified as having special/additional needs on the practice register have had an initial assessment by a multi disciplinary team and have an identified key worker and a personally tailored care (and transition if appropriate) plan.	100% of people identified as having special/additional needs on the practice register have had an initial assessment by a multi disciplinary team and have an identified key worker and a personally tailored care (and transition if appropriate) plan which are reviewed on at least an annual basis.	

3	Caring for and supporting people with long term and/or complex health and social care needs	Increased social inclusion of elderly and people with complex needs. Access availability of community nursing and day care services.	DHS/ CMO/ TLSW/ CNO	Vulnerable peoples strategy scoped and draft available. Mental Health strategy further developed.	100% of patients who fit the criteria identified as having a mental health problem that affects their ability to function in society are offered an intervention.	Vulnerable peoples strategy accepted by ExCo Develop and review annually a register of people with additional needs.	Maintain and continue to develop the multi-disciplinary assessment and care management process for people of all ages with additional needs including children	100% of people identified as having special/additional needs have had an initial assessment by a multidisciplinary team and have an identified key worker and a personally tailored care (and transition if appropriate) plan which is reviewed at least annually	
4	Actively addressing risk factors and behaviours to promote individual and family well being	People look after their teeth and take responsibility for their oral hygiene	SDO	Anecdotal evidence of poor dental hygiene	Establish an accurate measure of oral health in children - DMFT rate Appoint dental health advisor Continue active screening of children and follow up treatment initiated in schools	Publish and explain DMFT rate – review education campaigns Establish education campaign	Re-measure and review improvement in DMFT rate and once trend identified set target rates of improvement	Meet agreed target on improvement in children's DMFT rate	

5	Providing public protection in respect of health and social services	Identification of individuals who pose a risk Decrease in offending – violent (including domestic) sexual abuse, alcohol related.	CMO/TLSW	100% of recently convicted sex offenders have a management plan that is regularly reviewed	<5% of known sex offenders reoffend over a 5 year period.	90% of probation clients do not reoffend in their probation period Increase in reporting of violent offences including domestic by 25%	Anger management offered to all offenders 90% of discharged offenders do not reoffend in first year of discharge Increase in reporting by 50%.	Overall increase in reporting of violent offences of 50% and increase in conviction rate of 50% Anger management offered to all.	Increase in reporting continues as well as increase in the conviction rate.
6	Recruiting, equipping, developing, and empowering staff	Happy well motivated highly skilled staff with high morale and can do attitude	DHS/CMO CNO/TLSW E&EM	Recent FIG survey 70% of staff satisfied with work.	Complaints and compliments numbers published. Staff satisfaction survey carried out specific to H&SS and 75% of staff satisfied with their job Establish formal sickness monitoring	Actions on complaints reported to HMSC and numbers of complaints increased by 50% 100% of sickness is monitored and statistics collated	Complaints reviewed and action identified on repeat areas of complaint Staff satisfaction survey carried out specific to H&SS and 85% of staff satisfied with their job Reduction of 20% in short term sickness noted		Staff satisfaction survey carried out specific to H&SS and 85% of staff satisfied with their job

6. Risk Management

<u>HEALTH & SOCIAL SERVICES RISK MANAGEMENT MATRIX</u>										
Serial	Risk Description	Issue Impact / Probability		Status (RAYG)	Mitigation Description	Residual Issue Impact / Probability		Residual Status (RAYG)	Department Action Responsibility ¹	Comments
		I	P			I	P			
(a)	(b)	(c)		(d)	(e)	(f)		(g)	(h)	(i)
PRIMARY CARE										
GP1	Failure to recruit adequately qualified GP's resulting in failure to deliver adequate emergency and ongoing healthcare.	3	2	R	(a) Remove obstetrics as an essential GP requirement. (b) Remove secondary care as an essential requirement. (c) Improve terms and conditions to match UK expectations could potentially enhance recruitment. (d) Recruit nurse practitioners. (e) Recruit NP and EPN to take on some of the GP's role. (f) Potential secondments/sabbatical from UK would assist recruitment.	3	3	R	CMO	GP recruitment has historically been a problem - difficult to recruit for more than 3-4 months. (a) Whilst this would ease recruitment of GP's it will create a major problem in delivery of obstetrics. (b) Would create a division between primary & secondary care. Would require more secondary care doctors who would be under-utilised (e) Possible but there is a limit to the type and degree of cases manageable by a Nurse Practitioner.

GP2	Due to difficulty in recruitment, only being able to recruit GP's that do not have obstetrics skills.	3	2	R	Organise for those that wish to, to be sent overseas for support.	3	2	R	DHE / CMO	
GP3	Failure to recruit permanent GP's , resulting in loss of continuity of care and increased costs.	3	3	R	More detailed protocols NP and EPN to take on continuity role.	2	2	A	CMO	The lack of permanent GPs would have a negative impact on the GP service as a whole.
SECONDARY CARE										
SC1	Failure to recruit adequately qualified gp's resulting in potential poorer outcome for acute medical/paediatric emergencies	3	3	R	Increased training - 2 day acute emergencies course UCH Up-to-date policies and protocols reflecting best practice in UK adapted to local circumstances - needs links with an NHS Trust - initial enquiries in hand	1	2	Y	CMO	problem is large number of policies/protocols needed and impossibility of small number of staff keeping them up to date - so use NHS Trust as base documentation and review amendments annually
SC2	Inability to provide acute care to UK standards e.g. head injury/strokes/acute cardiac intervention etc	3	3	R	Accept limitations in policies and protocols	1	2	Y	CMO	
SC3	Lack of familiarity/skills in less common emergencies	3	3	R	policies and protocols increased training - in house and overseas	2	2	A	CMO	Will require more staff in order to find the time to do this

OBSTETRICS										
OB1	(a) Inability to recruit staff adequately trained in obstetrics (b) Potential massive ongoing costs of caring for handicapped child/adult due to lack of necessary obstetrics skills in Islands.	3	3	R	1. Stop doing obstetrics. 2. All GP's to undertake ASLO course regularly - limited benefit but measurable. 3. GP's/midwives to undertake hands-on refresher in UK regularly-	3	3	R	CMO / CNO	Very difficult to resolve - not a high enough workload to justify f/t obstetrician or for midwives to maintain skills if they upgrade their competence 1. Results in no deliveries in Falklands - political consequences 2. No comment. 3. Difficult now due to litigation issues
SURGICAL										
SUR1	Failure to secure satisfactory provider of surgical services in 2012 resulting in failure to provide essential surgical life/limb/eyesight saving surgery. Increased mortality and morbidity along with increased MTO costs.	3	2	R	Contract team and process in place. Island Health Services have indicated their willingness to tender in the short-term.	3	2	R	CE / DHE / CMO	Remains a real & major risk.
SUR2	Failure to secure satisfactory provider of services in 2017. Much higher risk than in 2012 because of decreasing pool of general surgeons. Resulting in failure to provide essential surgical life/limb/eyesight saving surgery, increased mortality and morbidity and increased MTO costs.	3	3	R	Partnership with NHS Trust or other provider – Question whether this is practical. DHE/CMO to engage in initial discussions with likely providers.	3	3	R	CE / DHE / CMO	
SUR3	Single surgeon/anaesthetist unavailable due to illness/injury.	3	2	R	GP anaesthetist for emergencies (increased risk) /urgent aero med/ provider to recruit locum	2	2	A	CMO / Surgical Contract Provider	Worked satisfactorily in the past

X-RAY										
X1	Single X-ray suite - equipment failure resulting in inability to provide X-rays	3	2	R	<p>Purchase 2nd digitiser/computer system as backup = high cost</p> <p>Use portable X-ray machine -limited range of X-rays - increased radiation</p> <p>Use image intensifier v limited range of X-rays and much increased radiation</p> <p>Regular servicing and planned early replacement of main unit</p>	1	1	G	CMO / X-Ray Provider / MEM	Risk v cost analysis needed
X2	Single radiographer unavailable due to illness/injury unable to provide X-rays resulting in diagnostic problems = increased mortality/morbidity	3	2	R	<p>Casualty nurses trained to undertake limited x-rays</p> <p>X-ray provider to have contingency plan</p>	1	2	Y	CMO / X-Ray Provider	
PUBLIC HEALTH										
PH1	Ward closure due to infectious disease.	3	3	R	<p>Isolation policy/MRSA screening/Infection control policy in place -regularly updated and constantly used and audited</p> <p>Norovirus a real risk from cruise ships - robust port health policy/isolate potentially infectious passengers - policy needed</p> <p>Purchase room sterilisation system or utilise cleaners.</p>	2	2	A	DHE / CMO / CNO / Lab Manager / Theatre Sister / Occ. Health Manager / Infection Control Committee	Impossible to eliminate risk but can limit effects.
PH2	Major accident/incident potential to overwhelm local services	3	3	R	<p>Major accident plan regularly exercised</p> <p>Needs overseas contingency support plan</p>	2	3	R	DHE / CMO / CNO / DoCS	Impossible to eliminate risk but can limit effects

GENERAL GP RISKS										
G1	Major event affecting KEMH unable to provide any satisfactory service - increased mortality/morbidity upgrade of fire alarm system/fire policy & training	3	2	R	contingency plan needed - identify emergency replacement structure (Field hospital)	3	1	A	DHE / CMO / CNO / MEM	Can reduce likelihood of this occurring but if it does will be major crisis.
G2	Loss of EMIS computing system = loss of records	3	2	R	Backup system and tapes held by computer dept - loss of 1 week's data	1	1	G	CMO / IT Department	
G3	Lack of succession planning - key posts difficult to replace	3	3	R	Produce succession plan - may be of limited benefit because of short notice periods	2	2	A	DHE	
SOCIAL SERVICES										
SS1	Unable to recruit suitably qualified social workers and/or team leader. No qualified social worker – unable to carry out statutory responsibilities in regard to child protection, ABE interviews, Approved Professionals under mental health ordinance.	3	2	R	Ensure that terms and conditions are competitive and that adverts well placed. Local succession planning and long-term training.	3	1	A	DHE / TLSS	
SS2	That the number of foster carers/resources is too limited for children received into care.	3	2	R	Foster care allowances are being increased and significant work is being done to expand the pool of potential foster carers.	3	1	Y	TLSS / DHE	
SS3	That the lack of awareness amongst professionals and the community results in increased levels of child sexual abuse.	3	2	R	Debate regarding sexual activity of minors to be looked into by safeguarding committee. Cross-agency working to try and pick up any issues and increase awareness.	3	1	Y	TLSS	
SS4	Risk that unsuitable or no legislation is in place to govern and protect social workers and their policies/procedures.	3	3	R	Legislation and policies being drafted and being submitted when ready to Executive Council for review and approval.	2	2	A	TLSS	

ENGINEERING										
E1	Breakdown of vital equipment within KEMH, meaning that certain procedures cannot be performed.	3	2	R	Regular maintenance is performed and spare parts held where feasible. Delivery by airmail of urgent parts can be organised. MoD assistance can be sought where helpful.	2	2	Y	MEM	
HEALTHCARE GOVERNANCE										
HG1	Accidents/Incidents/complaints not recorded/investigated – trends not identified resulting in high risk to organisation and malpractice claims.	3	3	R	All Accidents/ Incidents and complaints are reported, investigated and appropriate action taken	3	2	A	All departments	
DENTAL SERVICES										
D1	Unable to recruit suitably qualified Dental Officer/SDO/Dental Nurses.	3	2	R	Recruitment process begins well in advance and contacts are maintained with previous post-holders to try and ensure cover can be found. Locums can also be used.	3	1	Y	CMO / SDO	Additional cost likely if recruitment issues persist.
NURSING										
N1	Medication errors in nursing or in the community.	3	2	R	Medicines management policy. Staffing levels match complexity of medicine administration Staff thoroughly briefed on responsibilities Nurse prescribing course adapted for Falklands use Monitoring of incidents and review of trends. Use dosette boxes in the community when possible	2	2	A	CMO / CNO	Ensure patient staff family friends and carers understand.

N2	<p>Lone Working so lack of peer review, feeling of isolation, information about their work held in one place only</p> <p>Also particularly at risk of aggression, also difficult to manage emergencies.</p>	3	3	R	<p>Clinical supervision established either on Island or overseas or combination</p> <p>Team meetings</p> <p>Communal area such as a coffee room</p> <p>As much information as possible held in writing</p> <p>Access to at least two more people with an overview of the work.</p> <p>All have mobile phones available to them.</p>	2	2	A	CMO / CNO	
N3	<p>Staff not available in all professions in order to offer full service within resources in the Islands</p>	3	2	R	<p>Ensure recruitment using appropriate job descriptions and person specifications</p> <p>Link pay to UK or recognised recruiting country as an attractive choice</p> <p>Ensure policies procedures guidelines etc take into account availability and reality of staff situation and increased pressure when staff new or not available</p>	2	2	A	CMO / CNO / DHE	
N4	<p>Patient with increased BMI over the weight of the equipment that is available in the hospital, so patient could be injured by equipment failure.</p> <p>Staff can also be injured in moving individuals.</p> <p>Same applies in emergency situations.</p>	3	3	R	<p>A set of bariatric equipment available for use, cost approximately £25,000 would ensure that the patient is properly supported on the correct equipment which would reduce their risks of harm.</p>	3	1	Y	SMT	

N5	Cross-infection of hospital acquired infections	3	3	R	Tried and tested cross infection policy (use of hand gels etc). Screening of staff on induction and 3 monthly and screening of elderly care residents 3 monthly, all pre-arranged admissions, all emergency admissions., and all patients who return from MTO.	3	1	Y	Ward Manager	Remains a risk as community acquired risks are generally increasing and we do not screen all visitors
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Summary of Risk Form

GP = Primary Care

SC = Secondary Care

OB = Obstetrics

SUR = Surgery

X = X-Ray

PH = Public Health

G = General GP

HG = Healthcare Governance

E = Engineering

SS = Social Services

D = Dental Services

N = Nursing

Impact: Describe what effect the risk will have on the department. Represent the impact choosing the score from 0 to 3 (0 = satisfactory; 1 = slight; 2 = significant; 3 = severe).

Probability: Describe to the best of your knowledge the likelihood of the risk arising. Represent the probability by choosing the score from 0 to 3 (1 = unlikely (<5%); 2 = possible; 3 = probable (>50%).

Status: Representation of the status is by colour code as per legend (RAYG); critical risk = **Red**; serious risk = **Amber**; minor risk = **Yellow**; satisfactory = **Green**

Mitigation: Detail what action, if any, is proposed to reduce, manage or negate the stated issue. Should the department be unable to take action, the reasons should be explained.

Residual Impact: Forecast of the issue impact based on successful implementation of proposed mitigation. Represent the effect by using the key 0-3 for impact.

Residual Probability: Forecast of the potential of the risk materialising based on successful implementation of proposed mitigation. Represent the effect by using the key 0-3 for probability.

The forecast status of the issue following mitigation. Representation of the status is by colour code RAYG.

Department and individual responsible to undertake all or specific aspects of the mitigation action. To include POC details.