St Helena Government

# Health Directorate

# STRATEGIC PLAN 2019 –2022

## *Our Mission is to:*

*effectively and efficiently deliver within available resources, measurable improvements in the health outcomes of the population and to promote all efforts to achieve a healthy environment for all.*

# Health Directorate

# STRATEGIC PLAN 2019-2022

**Our Vision is to achieve longer and healthier life at all ages for the people of the island now and in the future**

**Our Mission is to effectively and efficiently deliver within available resources, measurable improvements in the health outcomes of the population and to promote all efforts to**

**Our Values: we are committed to ensuring our health services are driven by values that promote:**

- **safety first;**
- **effective service delivery;**
- **a caring and responsive workforce; and**
- **good governance and leadership**

## Our Strategic Priorities

**Priority 1 -** Maintain equitable and proportionate local access to a range of health services in partnership with the community for all and the most vulnerable

**Priority 2 -** Expand preventative healthcare services and promote healthy lifestyles for everyone

**Priority 3 -** Protect the population from clinical, environmental and other health threats and emergencies

**Priority 4 -** Tackle the high prevalence and incidence of chronic long term conditions among the population (diabetes, hypertension and kidney disease in particular)

**Priority 5 -** Provide access to specialist and tertiary care in a sustainable and affordable manner

**Priority 6 -** Ensuring that our existing and emerging health workforce needs are adequately met

**Priority 7 -** Improve community engagement and patient experience of the local health service

# Health Directorate

# STRATEGIC PLAN 2019-2022

## Welcome to the Health Directorate's Strategic plan for 2019-2022

Health is wealth, and wealth can facilitate better health. National economic prosperity is tightly linked to the health status of a nation in terms of having the resources to effectively pay and provide for the healthcare needs of the population and also ensuring that the population live long healthy years in order to contribute to economic development. It is well-known that poverty can and often lead to poor health and poor health can and adversely impact on economic well-being of individuals, families and communities. Better health has been shown to result in increased productivity and social participation throughout an individual's lifetime. Contemporary evidence across nations support the observation that healthier children experience better educational attainment, are more likely to attend school regularly and stay in education longer. This in turn improves their life chances and economic wellbeing as adults. Ill-health can have the double impact of reducing ability to earn income and possibly increase household expenditure significantly. A 'sick nation' is costly to the government, individuals, families and communities.

Our strategic approach to making us 'Altogether Healthier' is to prevent ill-health in this and future generations while ensuring that effective care is available in a sustainable manner when people become unavoidably unwell. This is a tough challenge for a small island nation like ours that is in the twilights of economic growth and highly dependent on financial aid and remittance from the diaspora. The technical capacity and capabilities required to deliver good quality healthcare on the island is limited and the cost of supporting access to specialist secondary and tertiary care is ever-increasing. This makes good health and healthcare even a more critical enabler to socio-economic development in a context where:

- the population is ageing fast and consequently require more healthcare input;
- service provision on the island is limited by available funding, low technology base, as well as the availability of required expertise;
- cost of care is ever-increasing due to inflation locally and overseas, high disease burden and the advent of new/expensive technologies;
- prevalence of long-term conditions is very high – ~25% of the population have been diagnosed with diabetes, ~30% with hypertension, and more than 70% of adults and 40% of children experience excess body weight with attendant risks to long term health and outcomes not optimal; and the
- prevalence of lifestyle and behavioural risk factors is high with 24% of teenagers and 20% of women in the reproductive age smoking regularly at significant risks to their health.

Plainly, it makes sense to invest in health and appropriate healthcare technologies, preventive services and treatments that can help reduce the lifetime cost of treatments and reduce levels of avoidable illnesses in the community. To that end over the next 3 years, we will continue to build on recent improvements in preventive care, health promotion, chronic disease management, increased community engagement and a better clinical governance framework. Our strategic intent is to continuously improve the health status and outcomes for current and future generations by:

- **Strengthening the delivery of effective and efficient services on the island;**
- **Implementing an effective Prevention and Health Promotion service; and**
- **Protecting the population from identifiable threats and hazards to health and ensuring a healthy environment.**

We will maintain current core services while taking every opportunity to support people to adopt healthier lifestyles, quit smoking, stop harmful alcohol use, maintain a healthy weight, and bring more care back to the island as safely as possible in order to reduce overall cost. We will partner with the community, our resident staff and overseas partners to achieve the best outcomes possible within available resources.

**Dr Akeem Ali, Director of Health**

# Health Directorate

# STRATEGIC PLAN 2019-2022

## OVERARCHING GOAL

***Altogether Wealthier***

## OVERARCHING STRATEGIC OBJECTIVE

*2.1 Improve the health of the community*

**Directorate Strategic Priority 1 –** Maintain equitable and proportionate local access to a range of health services in partnership with the community for all and the most vulnerable

**What is our target?** *(A target is an objective or result towards which efforts are directed)*

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Maintain access at 3 outpatient consultations/person/year for the general population | • Maintain access at 3 outpatient consultations/person/year for the general population | • Maintain access at 3 outpatient consultations/person/year for the general population |
| • Maintain service readiness for hospital occupancy rate of 50% | • Maintain service readiness for hospital occupancy rate of 50% | • Maintain service readiness for hospital occupancy rate of 50% |
| • Reduce the backlog of patients awaiting dentures by 80% | • Reduce the backlog of patients awaiting dentures to 0 | • Reduce the backlog of patients awaiting dentures to 0 |
| • Achieve 70% annual health check coverage for people with disabilities | • Achieve 90% annual health check coverage for people with disabilities | • Achieve 90% annual health check coverage for people with disabilities |
| • Waiting times for elective surgery maintained at less than 4 weeks | • Waiting times for elective surgery maintained at less than 4 weeks | • Waiting times for elective surgery maintained at less than 4 weeks |
| • Waiting time for regular outpatient appointments maintained at less than 2 weeks | • Waiting time for regular outpatient appointments maintained at less than 2 weeks | • Waiting time for regular outpatient appointments maintained at less than 2 weeks |
| • Tracer drugs available 90% of the time all year round | • Tracer drugs available 90% of the time all year round | • Tracer drugs available 90% of the time all year round |
| • Essential laboratory diagnostic tests available 90% of the time all year round | • Essential laboratory diagnostic tests available 90% of the time all year round | • Essential laboratory diagnostic tests available 90% of the time all year round |
| • Nurse Triage and Doctor on-call 24/7 all year round | • Nurse Triage and Doctor on-call 24/7 all year round | • Nurse Triage and Doctor on-call 24/7 all year round |

**What actions are needed to achieve that target?**

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Maintain weekly access to outpatient clinics at 3x community clinics | • Maintain weekly access to outpatient clinics at 3x community clinics | • Maintain weekly access to outpatient clinics at 3x community clinics |
| • Maintain daily access to outpatient clinics at 3x community clinics Jamestown | • Maintain daily access to outpatient clinics at 3x community clinics Jamestown | • Maintain daily access to outpatient clinics at 3x community clinics Jamestown |
| • Establish annual health check programmes for people with disabilities | • Expand annual health check programmes for people with disabilities | • Fully embed annual health check programmes for people with disabilities |
| • Maintain weekly clinical review sessions at social care residential facilities | • Maintain weekly clinical review sessions at social care residential facilities | • Maintain weekly clinical review sessions at social care residential facilities |

| | | |
|---|---|---|
| • Define the list of 'tracer drugs' and monitor stock-outs<br>• Define the list of 'essential laboratory tests' and monitor service readiness and availability<br>• Identify and recruit visiting specialists for prioritised clinical areas<br>• Identify and recruit medical engineering service company and establish a routine maintenance programme<br>• Conduct affordability survey for service user fees<br>• Explore alternative healthcare financing to ensure high affordability across the population as indicated<br>• Explore and identify opportunities for partnerships to deliver specialist care on the island using more visiting specialists<br>• Each service lead to create and implement operational plans to meet targets | • Monitor and report on availability of 'tracer drugs'<br>• Monitor and report on service readiness for 'essential laboratory tests'<br>• Identify and recruit visiting specialists for prioritised clinical areas<br>• Implement service maintenance schedule for all equipment<br>• Commence implementation of recommendations on alternative healthcare financing<br>• Establish facility to care for acute mental health clients on the island<br>• Undertake service efficiency reviews to identify opportunities to redeploy resources for prioritised objectives<br>• Each service lead to create and implement operational plans to meet targets | • Monitor and report on availability of 'tracer drugs'<br>• Monitor and report on service readiness for 'essential laboratory tests'<br>• Identify and recruit visiting specialists for prioritised clinical areas<br>• Implement service maintenance schedule for all equipment<br>• Monitor and report on the impact of alternative healthcare financing system if introduced<br>• Each service lead to create and implement operational plans to meet targets |

**What are the intended outcomes from each of these actions?** *(An outcome is the consequence/change or difference resulting from the action)*

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Access to defined essential services maintained<br>• No undue delay in access to planned services<br>• 24/7 access to appropriate emergency care | • Access to defined essential services maintained<br>• No undue delay in access to planned services<br>• 24/7 access to appropriate emergency care | • Access to defined essential services maintained<br>• No undue delay in access to planned services<br>• 24/7 access to appropriate emergency care |

# Health Directorate

# STRATEGIC PLAN 2019-2022

## OVERARCHING GOAL

***Altogether Wealthier***

## OVERARCHING STRATEGIC OBJECTIVE

*2.1 Improve the health of the community*

**Directorate Strategic Priority 2 –** Expand preventative healthcare services and promote healthy lifestyles for everyone

### What is our target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Offer brief intervention to 60% of outpatients who are smokers<br>• Recruit 50% of smokers (~400) into a smoking cessation programme<br>• Achieve 50% quit rate at 13 weeks among smoking cessation clients<br>• Offer brief intervention to 60% of outpatients with high BMI<br>• 50% of eligible patients with high BMI referred to structured weight management intervention<br>• 50% of patients referred to structured intervention fully participate and complete programme<br>• Undertake AUDIT-C assessment for harmful alcohol use for 100% of adult outpatient clients<br>• Establish brief intervention programme for harmful alcohol use<br>• 100% of school children have annual weight screening completed<br>• 60% Saints Together brand recognition amongst the population<br>• 50% of SHG workforce participating in the workforce wellbeing programme<br>• 15% increase in sales of Low Sugar carbonated drinks from | • Offer brief intervention to 80% of outpatients who are smokers<br>• Recruit 70% of smokers (~400) into a smoking cessation programme<br>• Achieve 60% quit rate at 13 weeks among smoking cessation clients<br>• Offer brief intervention to 75% of outpatients with high BMI<br>• 70% of eligible patients with high BMI referred to structured weight management intervention<br>• 60% of patients referred to structured intervention fully participate and complete programme<br>• Undertake AUDIT-C assessment for harmful alcohol use for 100% of new adult outpatient clients<br>• Establish brief intervention programme for harmful alcohol use<br>• 100% of school children have annual weight screening completed<br>• 60% Saints Together brand recognition amongst the population<br>• 70% of SHG workforce participating in the workforce wellbeing programme<br>• 25% increase in sales of Low Sugar carbonated drinks from | • Offer brief intervention to >80% of outpatients who are smokers<br>• Recruit >70% of smokers (~400) into a smoking cessation programme<br>• Achieve >60% quit rate at 13 weeks among smoking cessation clients<br>• Offer brief intervention to >75% of outpatients with high BMI<br>• >70% of eligible patients with high BMI referred to structured weight management intervention<br>• >60% of patients referred to structured intervention fully participate and complete programme<br>• Undertake AUDIT-C assessment for harmful alcohol use for 100% of new adult outpatient clients<br>• Establish brief intervention programme for harmful alcohol use<br>• 100% of school children have annual weight screening completed<br>• >60% Saints Together brand recognition amongst the population<br>• >70% of SHG workforce participating in the workforce wellbeing programme<br>• >25% increase in sales of Low Sugar carbonated drinks from |

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| baseline<br>• 20% increase in sales of Sugar-Free carbonated drinks from baseline | baseline<br>30% increase in sales of Sugar-Free carbonated drinks from baseline | baseline<br>>30% increase in sales of Sugar-Free carbonated drinks from baseline |

## What actions are needed to achieve that target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Establish a 'smoking cessation system' within the health service<br>• Establish a Tier 2 weight management service<br>• Establish an alcohol harm reduction programme within the health service<br>• Train relevant staff in brief intervention, smoking cessation support and other motivational interviewing technique<br>• Conduct quarterly audit of preventive service delivery in clinical consultations<br>• Implement all elements of the Health Promotion Strategy<br>• Evaluate current social marketing programme | • Maintain an effective 'smoking cessation system' within the health service<br>• Maintain a Tier 2 weight management service<br>• Maintain an alcohol harm reduction programme within the health service<br>• Train relevant staff in brief intervention, smoking cessation support and other motivational interviewing technique<br>• Conduct quarterly audit of preventive service delivery in clinical consultations<br>• Review the Health Promotion Strategy and make necessary changes to planned approach | • Maintain an effective 'smoking cessation system' within the health service<br>• Maintain a Tier 2 weight management service<br>• Maintain an alcohol harm reduction programme within the health service<br>• Train relevant staff in brief intervention, smoking cessation support and other motivational interviewing technique<br>• Conduct quarterly audit of preventive service delivery in clinical consultations<br>• Implement Revised Health Promotion Strategy |

## What are the intended outcomes from each of these actions?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Reduced prevalence of smoking by up to 10% from baseline<br>• Reduce prevalence of overweight and obesity among young people by up to 10% from baseline<br>• Reduce prevalence of obesity among adults by up to 5%<br>• Reduce prevalence of harmful alcohol use by 10% from baseline | • Reduced prevalence of smoking by up to 10% from baseline<br>• Reduce prevalence of overweight and obesity among young people by up to 10% from baseline<br>• Reduce prevalence of obesity among adults by up to 5%<br>Reduce prevalence of harmful alcohol use by 10% from baseline | • Reduced prevalence of smoking by up to 10% from baseline<br>• Reduce prevalence of overweight and obesity among young people by up to 10% from baseline<br>• Reduce prevalence of obesity among adults by up to 5%<br>Reduce prevalence of harmful alcohol use by 10% from baseline |

# Health Directorate

# STRATEGIC PLAN 2019-2022

## OVERARCHING GOAL

***Altogether Wealthier***

## OVERARCHING STRATEGIC OBJECTIVE

*2.1 Improve the health of the community*

**Directorate Strategic Priority 3 –** Protect the population from clinical, environmental and other health threats and emergencies

### What is our target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Healthcare associated infections maintained at zero<br>• 'Never Events' maintained at zero<br>• 100% of planned clinical audits completed<br>• 100% of planned port & environmental health inspections conducted<br>• >80% client satisfaction reported for the pest control service after intervention completed<br>• 100% of reported food and water-borne disease outbreaks investigated | • Healthcare associated infections maintained at zero<br>• 'Never Events' maintained at zero<br>• 100% of planned clinical audits completed<br>• 100% of planned port & environmental health inspections conducted<br>• >80% client satisfaction reported for the pest control service after intervention completed<br>100% of reported food and water-borne disease outbreaks investigated | • Healthcare associated infections maintained at zero<br>• 'Never Events' maintained at zero<br>• 100% of planned clinical audits completed<br>• 100% of planned port & environmental health inspections conducted<br>• >80% client satisfaction reported for the pest control service after intervention completed<br>100% of reported food and water-borne disease outbreaks investigated |

### What actions are needed to achieve that target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Establish an audit programme within the clinical governance system<br>• Prioritise the implementation of teaching, learning and clinical audits for all practitioners including doctors, nurses and other allied professionals<br>• Systematic implementation of lesson-learning events include Serious Untoward Incidents, Significant Adverse Events, Case, | • Implement annual clinical audit programme<br>• Monitor and report on incident management and lesson-learning<br>• Collate and report operational data, disease surveillance and population health vital statistics routinely<br>• Maintain food and water laboratory service and accreditation<br>• Conduct incident preparedness | • Implement annual clinical audit programme<br>• Monitor and report on incident management and lesson-learning<br>• Collate and report operational data, disease surveillance and population health vital statistics routinely<br>• Maintain food and water laboratory service and accreditation<br>• Conduct incident preparedness |

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| and Mortality and Morbidity Reviews<br>• Embed the new healthcare data collection system (PatientSource) suitable for the island<br>• Complete population epidemiological profile and population health needs assessment for the island<br>• Collate and report operational data and population health vital statistics routinely<br>• Establish routine disease surveillance and data analytics<br>• Recruit specialist environmental health workforce to support local team<br>• Maintain food and water laboratory service and accreditation<br>• Conduct incident preparedness planning and exercise such plans annually<br>• Train all relevant staff regarding major incident management | planning and exercise such plans annually<br>• Train all relevant staff regarding major incident management | planning and exercise such plans annually<br>• Train all relevant staff regarding major incident management |

## What are the intended outcomes from each of these actions?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Reduction in the number of reported clinical errors<br>• Improved clinical outcomes<br>• Reduced complication rate<br>• Readiness and effective response to health threats and incidents | • Reduction in the number of reported clinical errors<br>• Improved clinical outcomes<br>• Reduced complication rate<br>Readiness and effective response to health threats and incidents | • Reduction in the number of reported clinical errors<br>• Improved clinical outcomes<br>• Reduced complication rate<br>Readiness and effective response to health threats and incidents |

## OVERARCHING GOAL

***Altogether Wealthier***

## OVERARCHING STRATEGIC OBJECTIVE

*2.1 Improve the health of the community*

**Directorate Strategic Priority 4 –** Tackle the high prevalence and incidence of chronic long term conditions among the population (diabetes, hypertension and kidney disease in particular)

### What is our target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • >80% of patients living with diabetes receive annual HbA1c check<br>• >80% of patients living with diabetes receive annual retinopathy screening<br>• % of patients living with diabetes with poor control reduced from 45% to <20%<br>• >60% of patients living with hypertension receive annual review<br>• Systematic lifestyle intervention made available as indicated to >50% of patients living with long term conditions | • >80% of patients living with diabetes receive annual HbA1c check<br>• >80% of patients living with diabetes receive annual retinopathy screening<br>• % of patients living with diabetes with poor control reduced to <10%<br>• >70% of patients living with hypertension receive annual review<br>Systematic lifestyle intervention made available as indicated to >70% of patients living with long term conditions | • >80% of patients living with diabetes receive annual HbA1c check<br>• >80% of patients living with diabetes receive annual retinopathy screening<br>• % of patients living with diabetes with poor control at <10%<br>• >80% of patients living with hypertension receive annual review<br>• Systematic lifestyle intervention made available as indicated to >80% of patients living with long term conditions |

### What actions are needed to achieve that target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Systematically learn from similar healthcare systems that have successfully tackled high prevalence of non-communicable diseases<br>• Design and implement an integrated long term condition control programme<br>• Identify and recruit short and long-term specialist expertise for chronic disease management as required<br>• Establish a chronic disease control and prevention team<br>• Establish clinical standards and protocols for chronic disease care<br>• Explore the introduction of patient activation monitoring clinical tool<br>• Explore the implementation of dialysis and treatment for chronic | • Maintain and expand Year 1 interventions as required;<br>• Introduce Patient Activation Measures into clinical care to aid the introduction of self-management programme<br>• Establish 'expert-patient or self-management programme for long-term conditions<br>• Identify and recruit expertise as required to strengthen service delivery<br>• Conduct further needs assessment<br>• Conduct evaluations and service reviews | • Maintain and expand Years 1 & 2 interventions as required<br>• Renew the design of primary care services to tackle long term conditions<br>• |

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| kidney disease on the island<br>• Train relevant practitioners and establish standards and protocols for care | | |

## What are the intended outcomes from each of these actions?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Reduced complication rate from chronic diseases – diabetes and hypertension in particular | • Reduced complication rate from chronic diseases – diabetes and hypertension in particular | • Reduced complication rate from chronic diseases – diabetes and hypertension in particular |

# Health Directorate

# STRATEGIC PLAN 2019-2022

## OVERARCHING GOAL

***Altogether Wealthier***

## OVERARCHING STRATEGIC OBJECTIVE

*2.1 Improve the health of the community*

**Directorate Strategic Priority 5 –** Provide access to specialist and tertiary care in a sustainable and affordable manner

### What is our target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Reduce waiting times for urgent overseas referral to ≤3 months<br>• Reduce average cost of overseas treatment per patient by up to 5%<br>• Maintain comparative good outcomes after overseas treatment<br>• Conduct annual 'Value For Money' Review of Overseas Referrals | • Reduce waiting times for urgent overseas referral to ≤3 months<br>• Reduce average cost of overseas treatment per patient by up to 5%<br>• Maintain comparative good outcomes after overseas treatment<br>Conduct annual 'Value For Money' Review of Overseas Referrals | • Reduce waiting times for urgent overseas referral to ≤3 months<br>• Reduce average cost of overseas treatment per patient by up to 5%<br>• Maintain comparative good outcomes after overseas treatment<br>Conduct annual 'Value For Money' Review of Overseas Referrals |

### What actions are needed to achieve that target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Collect and analyse data on costs, outcomes and patient experience<br>• Undertake robust estimate of funding needs for overseas and specialist treatment off-island<br>• Identify and implement opportunities to reduce avoidable cost of overseas treatment<br>• Negotiate favourable pricing arrangements with overseas clinicians and medical facilities<br>• Review contracting arrangements for overseas treatment to achieve further cost reduction through negotiated agreements<br>• Explore and identify other locations for overseas referral with potential for reduced cost (in light of expected reviews of air access arrangements) | • Collect and analyse data on costs, outcomes and patient experience<br>• Undertake robust estimate of funding needs for overseas and specialist treatment off-island<br>• Fully implement all identified opportunities to reduce avoidable cost of overseas treatment<br>• Negotiate favourable pricing arrangements with overseas clinicians and medical facilities<br>• Implement contract review recommendations<br>• Implement any newly identified overseas referral arrangements that is supported | • Collect and analyse data on costs, outcomes and patient experience<br>• Undertake robust estimate of funding needs for overseas and specialist treatment off-island<br>• Fully implement all identified opportunities to reduce avoidable cost of overseas treatment<br>• Negotiate favourable pricing arrangements with overseas clinicians and medical facilities |

## What are the intended outcomes from each of these actions?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Reduced case fatality rate among patients requiring specialist/tertiary care that is not available on the island | • Reduced case fatality rate among patients requiring specialist/tertiary care that is not available on the island | • Reduced case fatality rate among patients requiring specialist/tertiary care that is not available on the island |

# Health Directorate

# STRATEGIC PLAN 2019-2022

## OVERARCHING GOAL

***Altogether Wealthier***

## OVERARCHING STRATEGIC OBJECTIVE

*2.1 Improve the health of the community*

**Directorate Strategic Priority 6 –** Ensuring that our existing and emerging health workforce needs are adequately met

### What is our target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Defined essential clinical positions filled all year round<br>• Planned transition arrangements in place for 100% of incumbent TC posts<br>• Succession plans in place for all nursing, laboratory and environmental health posts<br>• 100% of identified competency gaps have intervention plans in place<br>• All staff complete annual appraisal<br>• 100% of staff have personal development plan in place<br>• All service posts that Saints are willing to undertake overseas training to fill are identified and included in SHG's corporate training development plans | • Defined essential clinical positions filled all year round<br>• Planned transition arrangements in place for 100% of incumbent TC posts<br>• Succession plans in place for all nursing, laboratory and environmental health posts<br>• 100% of identified competency gaps have intervention plans in place<br>• All staff complete annual appraisal<br>• 100% of staff have personal development plan in place<br>All service posts that Saints are willing to undertake overseas training to fill are identified and included in SHG's corporate training development plans | • Defined essential clinical positions filled all year round<br>• Planned transition arrangements in place for 100% of incumbent TC posts<br>• Succession plans in place for all nursing, laboratory and environmental health posts<br>• 100% of identified competency gaps have intervention plans in place<br>• All staff complete annual appraisal<br>• 100% of staff have personal development plan in place<br>All service posts that Saints are willing to undertake overseas training to fill are identified and included in SHG's corporate training development plans |

### What actions are needed to achieve that target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Establish an annual continuous professional development programme (CPD) for all staff cadres to strengthen local expertise and reduce reliance on expatriate staff where practicable<br>• Identify and support local staff for long term skills and capability training<br>• Identify potential partnerships with tertiary health professional training institutions across the world<br>• Identify and establish funding requirements for long-term workforce development<br>• Support current staff undergoing | • Implement annual CPD programme plan<br>• Identify and support local staff for long term skills and capability training<br>• Implement partnership arrangements for recruiting specialist staff<br>• Implement partnership arrangements for training staff<br>• Undertake regular competency review and update skills<br>• Undertake annual staff appraisal<br>• Implement plans regarding professional networking for lone professionals working on the island for supervision and | • Implement annual CPD programme plan<br>• Identify and support local staff for long term skills and capability training<br>• Implement partnership arrangements for recruiting specialist staff<br>• Implement partnership arrangements for training staff<br>• Undertake regular competency review and update skills<br>• Undertake annual staff appraisal<br>• Implement plans regarding professional networking for lone professionals working on the island for supervision and |

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| degree training to complete successfully<br>• Undertake regular competency review and update skills<br>• Identify and develop professional network links for lone professionals working on the island for supervision and professional development<br>• Strengthen CPD programme and participation for all practitioners working in the directorate<br>• Explore, identify and establish operational links with tertiary health professional training institutions across the world to supply specialists and trained personnel to the island<br>• Undertake annual staff appraisal | professional development | professional development |

## What are the intended outcomes from each of these actions?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Staff competency assured and maintained<br>• Service readiness maintained through adequate workforce | • Staff competency assured and maintained<br>• Service readiness maintained through adequate workforce | • Staff competency assured and maintained<br>• Service readiness maintained through adequate workforce |

## OVERARCHING STRATEGIC OBJECTIVE

### *2.1 Improve the health of the community*

### Directorate Strategic Priority 7 – Improve community engagement and patient experience of the local health service

#### What is our target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • 100% of service sections systematically collect patient feedback through an auditable system<br>• Patient complaints are reviewed and responded to within the agreed timeline<br>• All patients with mental health needs have a care plan that they agreed to in place<br>• All patients receiving palliative care have a care plan that they agreed to in place | • 100% of service sections systematically collect patient feedback through an auditable system<br>• Patient complaints are reviewed and responded to within the agreed timeline<br>• All patients with mental health needs have a care plan that they agreed to in place<br>• All patients receiving palliative care have a care plan that they agreed to in place<br>• Evidence of community participation in the development of the next strategic plan documented | • 100% of service sections systematically collect patient feedback through an auditable system<br>• Patient complaints are reviewed and responded to within the agreed timeline<br>• All patients with mental health needs have a care plan that they agreed to in place<br>• All patients receiving palliative care have a care plan that they agreed to in place |

#### What actions are needed to achieve that target?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Maintain and report on patient feedback, complaints, compliments and incidents<br>• Open public health committee sessions for community to participate fully<br>• Facilitate community group and advocacy using established channels and new ones | • Maintain and report on patient feedback, complaints, compliments and incidents<br>• Open public health committee sessions for community to participate fully<br>• Facilitate community group and advocacy using established channels and new ones | • Maintain and report on patient feedback, complaints, compliments and incidents<br>• Open public health committee sessions for community to participate fully<br>• Facilitate community group and advocacy using established channels and new ones |

#### What are the intended outcomes from each of these actions?

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Improved client and patient satisfaction | • Improved client and patient satisfaction | • Improved client and patient satisfaction |

# Health Directorate
# STRATEGIC PLAN 2019-2022

## DIRECTORATE VALUES

### Safe care at all times

- **By safe, we mean that people are protected from abuse and avoidable harm**

### Effective use of resources for appropriate care

- **By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence**

### Caring for all clients

- **By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect**

### Responsive to client needs

- **By responsive, we mean that services are organised so that they meet most of people's needs based on available resources**

### Accountable and well-led service for the community

- **By well-led, we mean that the leadership, management and governance of the organisation is answerable for and assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture**