



**GOVERNMENT OF ST HELENA**  
**OPERATIONAL PLAN**  
**Health Directorate**  
**2015-2018**

Version no: v1

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**Contents**

SECTION 1    CONTEXT AND ANALYSIS ..... 3

SECTION 2    DETAILED ACTION PLANS..... 32

SECTION 3    OPERATIONAL RISKS .....10

## SECTION 1      CONTEXT AND ANALYSIS

### 1      Introduction

The organisational structure and resources for the Health Directorate are identified in the sections below, as are an overview of the services Health provide, our performance to date and key Workforce Planning issues.

### 2.    Your organisations structure and resources

The Directorate provides a diverse range of services, with the Director of Health heading the Directorate as per the organogram below with four senior staff directly reporting to the Director, as follows:

- Clinical Director / Senior Medical Officer who has a clinical lead responsibility as well as line management responsibility for Environmental Health, Laboratory and Pharmacy services.
- Dentist responsible for the island's dental care.
- Acute and Community Health Manager who is responsible for all nursing services in the community and hospital.
- Assistant Director of Health who stands in for the Director as required and has specific responsibilities for the administrative support to all sections of the Directorate, including budgeting, staff recruitment and building maintenance

The Directorate currently operates from the following locations:

- The General Hospital and Dental Clinic in Jamestown
- Primary care clinics in Jamestown, Longwood, Levelwood, and Half Tree Hollow
- The Administration block in Jamestown, adjacent to the general hospital
- St Johns' Villa at the rear of the general hospital for community nursing and mental health services
- Adult and Vocational Education Centre in Jamestown, where the School of Nursing is based
- AVES, where the School of Nursing is based

The Directorate currently employs a total of 106 staff although some staff shortages have been identified and some key posts identified and

agreed in the DAPM discussions 2014 not being funded. The majority of our staff are employed in nursing functions, with only small numbers being employed in the Laboratory, Dental and Pharmacy sections. Staffing numbers will reduce as and when individual staff become more competent/qualified to fulfil their daily tasks which would enable them to take on additional duties/responsibilities.

This plan covers the years 2015-2018 and covers the activities of the Directorate and also includes the activities of:

- Public Health Committee
- Health Protection Board which acts as the Competent Authority for the purposes of the Fish and Fish Products Ordinance 2010 and the enforcement of the International Health Regulations
- Safeguarding Children's Board

The plan is consistent with and feeds into the St Helena Sustainable Development Plan 2015-2018 and the SHG Strategic Plan 2015-18.

The guiding legislation for the Directorate includes:

- The Public Health Ordinance, Cap 49 and associated Regulations
- The Public Health (Amendment) Ordinance 2010
- The Fish and Fish Products Ordinance, 2010 and associated Regulations
- The Food Hygiene Regulations, 2003
- The Port Health Ordinance, Cap 62
- The Mental Health Ordinance, Cap 57
- The Coroner's Ordinance, Cap 11
- The Medical Practitioners Ordinance, Cap 50
- The Dentists Ordinance, Cap 51
- The Nurses and Midwives Ordinance, Cap 52
- The Pharmacy and Poisons Ordinance, Cap 53
- The Health and Safety Ordinance, Cap 54 and associated Regulations
- The Welfare of Children Ordinance, 2008 and associated Regulations
- The Agriculture and Livestock Ordinance, Cap 94 (The Rodent Control and Destruction Rules)
- Dogs and Cats Ordinance, Cap 163

This Plan draws upon the following documents:

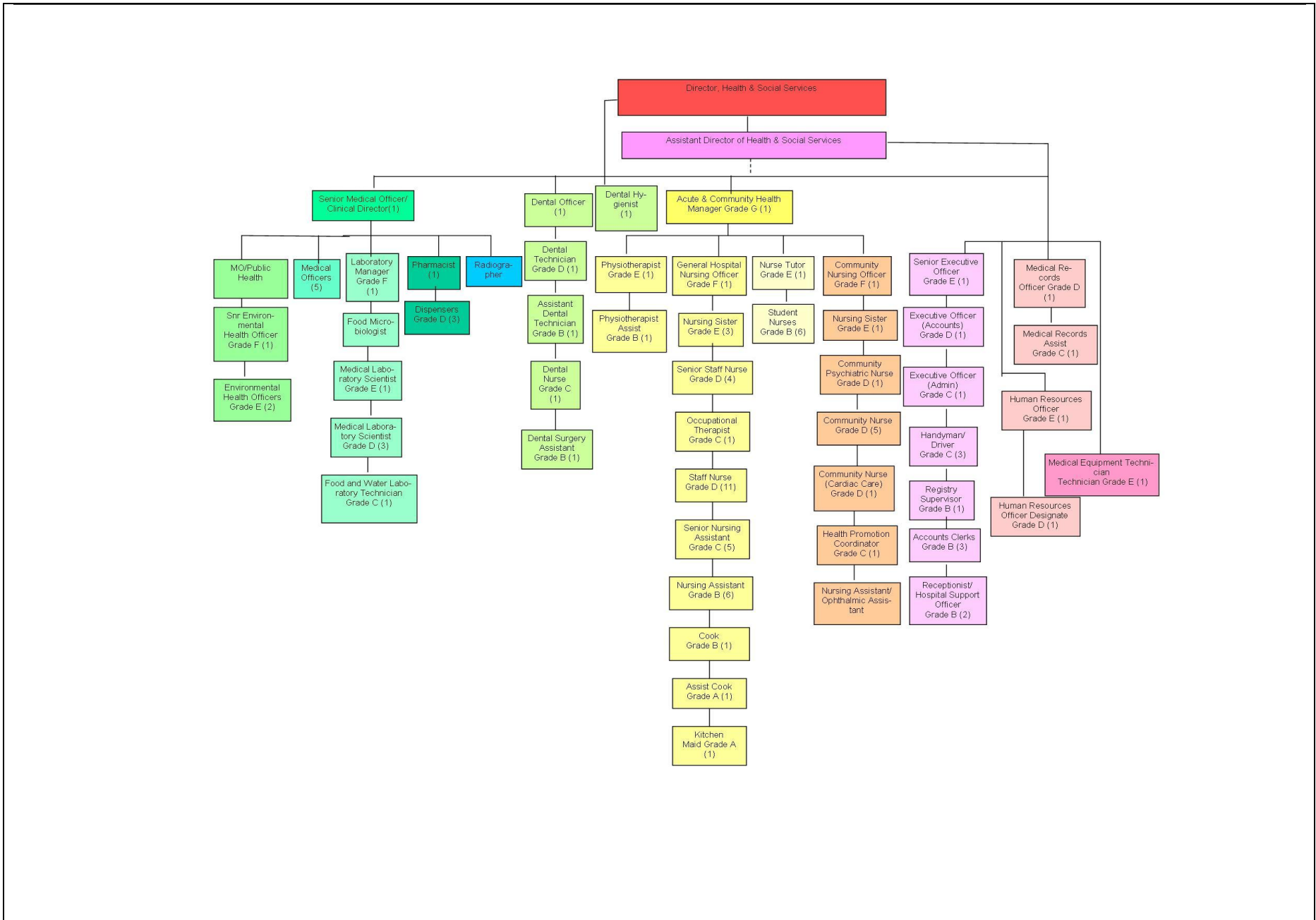
- The St Helena Public Health and Social Services Development Strategy appraisal 'What's New' and 'What's Next' , Jenny McNeill 2011
- SHG Divestment Strategy 2011
- Cost-effective delivery of specialist medical services report, Lasse Nielson, 2011.
- Solid Waste Management Strategy 2012
- National Environment Strategy 2012
- Directorate's progress reports and various visiting specialist/consultants' and NHS New Devon reports
- DHSW expenditure report 2011/12 and 2013/14 and budget allocations for 2014-2017
- Lucy Faithfull Foundation report 2013
- NHS Institute for Innovation and Improvement Functional Analysis, 2013

The Health Directorate 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 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.

### 3. Organogram

# Operational Plan for Health Directorate/Section | 2015-18



#### 4. The services you provide

- Community and Primary Care Services, including Outpatient clinics at 4 locations around the Island, namely Longwood, Levelwood, Half Tree Hollow and Jamestown; School Health; some industrial screening; community nursing services; specialist nurse led clinics for those with long term conditions, Mental Health services; Physiotherapy; Radiography and Ultrasound as well as family planning and women and child health clinics.
- Medical and Nursing services, including hospital services such as surgery, acute care, maternity and accident and emergency services.
- Nurse Education through the School of Nursing.
- Physiotherapy and Occupational Therapy services.
- Dental services.
- Environmental Health services including meat and fish inspections, quality control of water provision, food hygiene and safety, port health and workplace health and safety.
- Laboratory services including Phlebotomy, Bio-medical lab services, fish, meat, food and water testing services, pathology testing.
- Pharmacy services in Jamestown and mobile pharmacy services to support outpatient clinics.
- Administration services providing support to all sections of the Directorate, which employs a total of 106 full-time staff. These 106 employees provide all the functions of a highly complex service requiring confidentiality, high standards of infection control, great integrity and various professional skills. 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 frequently at their most vulnerable when interacting with the health services.

#### 5. Your performance to date

Social Services have been badly hit by losses of key staff, difficulties in recruitment, appalling media coverage of a leaked draft Lucy Faithful Foundation report, difficult cases and management of these, poor data gathering, collation and analysis, and poor multi-agency working. It is pleasing to note that in the latter part of the reporting period that the employment of new TC staff, new ways of working (including multi-agency relations), documentation systems plus greater management and Dfid support have turned this situation around. There is a new social services strategy being worked up which will culminate in Social Services being split away from Health and probably forming its own Directorate. As agreed internally the current Director of Health and Social Services is not including Social Services in his Strategic Plan or associated Budgetting processes.

Community and Primary Care Services have suffered during the last reporting period due to the lack of staff. Outpatient clinics have frequently

had to be cancelled, sometimes with little notice and there has, on a number of occasions, been public concerns raised. Community nursing services have been stretched, again due to the lack of staff. The Mental Health services, which currently carries a caseload of around a hundred clients, have also been hindered by the lack of TC staff recruitment.

Medical and Nursing services, including hospital services such as surgery, acute care, maternity and accident and emergency services have been very difficult to manage at times, so much so that members of the general public and other SHG staff have, at times, had to be requested to assist. This need directly relates to the lack of staffing number and the need for better staff clinical competencies.

Nurse Education through the School of Nursing continue to manage the development of local nursing staff, this includes the delivery of mandatory training as well as pre-registration education. There is a significant need to either develop this educational requirement or consider the stopping of pre-Registration nurse training and education on island.

Physiotherapy, Occupational Therapy and Radiography services are of a high standard and have been delivered without problem and the same can also be said of the Radiography and Ultrasound Services; all of whom have been very busy. The only real problem has been with significant radiological equipment problems, relating to dated equipment and associated failures, which has been addressed.

Dental services have continued to be delivered to a high standards and the department has been very busy. All school children have been treated, when required, within 4 months of school screening. The dental department has started to develop higher standards in relationship to the attainment, where possible, of HTM015 compliance and the drafting of new evidence-based policies and procedures. There remains a large backlog of patients to be seen and such is the extent of the foreseeable ongoing requirement there is a need to develop the service further. The appointment of a full time Senior Dentist will improve patient access and supply of dental treatment to all islanders and improve the dental health of the population. The role will continue to develop the writing, implementation and monitoring of protocol, policies and procedures to achieve, where possible, UK care quality commission standards. It will also enable better training of dental personal. Improved diagnostics have resulted in increased diagnosis in untreated caries and periodontal disease.

Environmental Health services including solid waste management, meat and fish inspections, quality control of water provision, food hygiene and safety, port health and workplace health and safety have all ensured that the department have been very busy. The internal divestment of pest and solid waste management to ENRD has been delayed however, it should still occur in the F/Y 2014/15. The requirement to take forward Food Safety standards include the need to address problems associated with backyard slaughtering; the management of swordfish whose mercury levels mean that they are unfit for human consumption and the testing of water to ensure it is fit for human consumption have all meant that a considerable amount of draft legislative writing and public discussion has had to take place. The bottom line is that standards have to be improved, appropriate legislation, which has been drafted, needs to be supported and the Environment Health team will need to develop further their monitoring function.



Laboratory services including Phlebotomy, Bio-medical lab services, fish, meat, food and water testing services, pathology testing have also been very busy. The department outputs are high; both in terms of the quantity of investigations made but also regarding the quality, including EU accreditation standards and in relation to the breadth and depth of examinations undertaken. The potential to further develop the haematology service when the airport comes on line is an area that needs to be developed.

Pharmacy services have continued to supply in Jamestown and mobile pharmacy services to support outpatient clinics. Increasingly the pharmacy is providing a minor illness service utilising the skills and knowledge of the UK pharmacist. Work has been ongoing to develop a revised medicines formulary, which will provide a rationalisation of medicines held as well as confirming that the most appropriate, in clinical and financial terms, are held.

Administration services have continued to be busy in providing support to all sections of the Directorate.

Challenges that need to be addressed relate to:

- Delivering a strategy for sustainable healthcare on St Helena identifying synergies, cross cutting issues and gaps to be addressed. This will include the potential for healthcare rationing, further embedding healthcare governance and risk management, developing health promotion, enhancing staff clinical competencies.
- Defining the role and function for a new build hospital; agreed in principle as an integrated healthcare service with a new hospital at the hub of the service.
- Develop a framework of generic principles of service delivery for primary care; this ties into staff meeting clinical competencies and working as autonomous practitioners.
- Develop an education strategy, for pre and post registration nursing and for allied health professionals that is tailored to the needs of the island and where possible meets the criteria for an internationally recognised qualification; this inherently means developing linkages to an external educational provider and the use of a blended learning approach.
- Develop a robust referral system for patients to access medical treatment overseas if treatment not available on island this includes makes a clear distinction between patients that can travel on scheduled flights and those requiring an Air Ambulance; this work needs to be continued with a specialist provider and a Service Level Agreement needs to be agreed and outputs monitored.

As St Helena moves to air access the one area that is most likely to be affected is the island health service. It will bring many benefits to the service. The challenge will be in making the most efficient use of the new opportunities for treatment and in financing the increased costs.

This analysis draws on more detailed performance monitoring and evaluation reports including *(insert titles of any internal or external evaluation or review exercises undertaken in the last 12 months)*

Output (Service/Function)	Areas of success	Areas for improvement	Lessons learned	Key challenges for 2015-2018
<p><b>Mental Health</b> – Consultant Clinical Psychologist</p>	<ul style="list-style-type: none"> <li>• Mental Health First Aid courses &amp; Youth Mental First Aid courses delivered to a number of people in the public/private sectors and in PAS school.</li> <li>• The number of pts diagnosed with serious and enduring mental health illness remains stable and are maintained in the community with only occasional acute admissions.</li> <li>• All children on psychotropic medication are now being reviewed in line with UK protocols. A register is kept</li> </ul>	<ul style="list-style-type: none"> <li>• Safetalk awareness/prevention/intervention programmes be rolled out on island &amp; a member of the health directorate be seconded for the training for Trainers Course in the UK.</li> <li>• To set up trauma groups/individual work for adult survivors of sexual abuse &amp; use of a manualised programme for mothers of sexually abused children provided staff are trained and supervised to do this work.</li> <li>• Provision of a dedicated treatment space &amp; an additional therapy room in a less exposed setting.</li> <li>• A mental Capacity Act is recognised as being an essential piece of legislation in protecting vulnerable clients. Policies need to be developed for the implementation of the Act.</li> <li>• Caldicott Principles need to be adopted &amp; a protocol developed for access to medical information regarding the way in which paper records are kept &amp; disposed of.</li> </ul>	<ul style="list-style-type: none"> <li>• It is important that 2 CPN's be recruited/in post at any one time to sustain the quality and responsiveness of the mental health service.</li> <li>• When recruiting, it is vital that one of the GP's has a special interest/experience/ training in mental health which is important for integrating healthcare services and breaking down the artificial division between physical and mental health.</li> </ul>	

	of these pts.			
<b>Pathology - SBS</b>				
<b>Optometry</b>		<ul style="list-style-type: none"> <li>• Differentiation of the various activities within the Primary Eye care service, with requisite changes in clinical appointment schedule to encompass some elements of secondary care for specific patients</li> <li>• Introduction of dedicated Glaucoma Monitoring Service which would promote efficient use of finite clinical time</li> <li>• Dedicated Biometry Service since the instrument requires calibration on each occasion before use</li> <li>• Introduction of Eye-care Referral request form - Clarification of reason for referral would improve efficiency of booking system and promote identification of and better communication with referring HCP Improved documentation of referral pathway and remote advice should be clearly documented in the EMIS electronic patient record to promote best practice in reporting and share care of a patient.</li> <li>• Revision of Fees Schedule related to different services, and/or amendment to the wording of the current schedule to reflect the diverse clinical activities undertaken by the optometrist in both primary and secondary care.</li> <li>• Measures to promote up-take of Diabetic Retinopathy Screening service, use of patient education leaflet. Re-instatement of the use of the Register of Persons with Diabetes as the recall database</li> </ul>		
		<ul style="list-style-type: none"> <li>• Full clinical data should be available for remote grading of digital</li> </ul>		

		<p>images.</p> <p>Measures to improve compliance with glaucoma treatment i.e.</p> <ul style="list-style-type: none"> <li>• Patient education leaflet</li> <li>• EMIS alert for repeat prescription of medication</li> <li>• Label on medication package</li> <li>• Dedicated glaucoma monitoring service</li> </ul> <ul style="list-style-type: none"> <li>• Specific definitions of Visual Disability to be included in the criteria for the Disability Register held by the Social Welfare department</li> <li>• Formal protocol for certification of Visual Impairment</li> </ul> <p>Extension of the Skills base for HCPs as the skills base is very restricted with only one or two HCPs having skills in various specific eye-care duties. The sustainability of local services is vulnerable due to the reliance on only one person, the Ophthalmic Assistant</p> <ul style="list-style-type: none"> <li>• Mandatory basic training in Visual Acuity assessment for Triage Nurses</li> <li>• Training for another HCA to support the Ophthalmic Assistant</li> </ul> <p>Experience of Ophthalmic Accident &amp; Emergency care for a resident Medical Officer</p> <p>A long-term plan for maintenance and capital investment in ophthalmic equipment should be established.</p> <p>Devolvement of Spectacles Dispensing service</p>	<ul style="list-style-type: none"> <li>• Patient education promotes better up-take of the service particularly amongst newly diagnosed patients. Good patient education promotes good self-management of diabetes with the result improvement in the prevalence of ocular and systemic complications.</li> </ul> <ul style="list-style-type: none"> <li>• Poor compliance with life-long</li> </ul>		
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			<p>medication has a very significant adverse visual outcome for persons with glaucoma. An understanding of good self-management is vital for this chronic disease</p>	
<p><b>Gynaecology/Obstetrics</b></p>		<ul style="list-style-type: none"> <li>• Any investigation where a sample needs to be sent off island for analysis needs to be justified in discussion at the referral meeting.</li> <li>• As all doctors are involved in prescribing contraception there should be a CPD activity to ensure that they and the nursing staff dispensing contraceptive supplies are updated and familiar with the WHO and FRSH guidelines on contraception.</li> <li>• All women taking Dianette should be counselled about the increase in risk of VTE and have alerts added to their EMIS record to ensure that the preparation is changed once the symptoms for which it was prescribed have settled.</li> <li>• Marvelon should replace Trinovum and be considered for use in place of Dianette for women with acne.</li> <li>• Add a 20 microgram preparation such as Mercilon to the formulary of oral contraception.</li> <li>• Increase the number of Nexplanon implants in stock and ensure regular reorder.</li> <li>• Keep Multiload Cu375 as an option for emergency contraception, procuring CuT 380 devices as first choice for long term intrauterine contraception.</li> <li>• Mirena IUS should continue to be available on St Helena for contraceptive and therapeutic indications.</li> <li>• Filshie clips and a Filshie clip applicator should be purchased for the preferred method of female sterilisation where alternative long term</li> </ul>		

		<p>methods of contraception are not suitable.</p> <ul style="list-style-type: none"> <li>• Any woman declining to attend for a smear on phone call from a community nurse should have the opportunity to speak to the gynaecologist to explore further the reasons for avoiding smears and this offer should be clearly documented in the medical record.</li> <li>• Complete the protocol on management of abnormal cervical smears, to be developed in line with the UK guidelines.</li> <li>• Arrange with the pathology laboratory in Cape Town that HPV testing will be performed on "ASCUS" and "LSIL" smears.</li> <li>• All women with "ASCUS – high grade cannot be excluded" or "AGCUS" results should undergo Colposcopy.</li> <li>• Procure a colposcope for use in the gynaecologist consulting room in the Community Health Clinic (with use in theatre in exceptional rather than routine cases) when an appropriate gynaecological examination chair is acquired. Alternatively, the colposcope could be used in the delivery room, where the bed can be adapted into a suitable position for colposcopy. Ensure that all necessary equipment for colposcopy and colposcopic procedures is purchased. This should include various sizes of cervical punch biopsy forceps, suitable vaginal specula, appropriate adhesive earthing pads, a greater selection of reusable wire loops and balls and a vapour evacuation unit.</li> <li>• Refresh the knowledge of all ages of the public about sexually transmitted infections and how they can be prevented.</li> <li>• Offer chlamydia screening annually to all under-25 year old women, starting at whatever age sexual activity commences.</li> <li>• Consider obtaining bench-top tests for gonorrhoea for use in those testing positive for other STIs or who are symptomatic.</li> <li>• Continue to promote the availability of confidential HIV testing and offer to any person presenting with a STI.</li> <li>• Infacol should not be supplied by the hospital pharmacy. If parents wish to use it they should purchase it elsewhere.</li> <li>• All relevant staff update on evidence based breast-feeding support.</li> <li>• There should be a clear understanding about what conditions will be screened for if the newborn metabolic screening test is transferred to Cape Town. The decision to transfer this service should not be made</li> </ul>			
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		<p>on cost alone.</p> <ul style="list-style-type: none"> <li>• For improved continuity and to provide more opportunity for practice given the small numbers of pregnancies annually, the midwives' duties should be concentrated on women's reproductive health issues so that they can be available to attend all pregnancy related consultations as in- and out-patients, both antenatal, intrapartum and postnatal. Under the oversight of the clinical management team (including the obstetrician and gynaecologist), the midwives can be supported by two or three community trained staff and care assistants of appropriate calibre and experience.</li> <li>• A short term (4 to 6 months) team of two or three midwives be recruited to evaluate the current situation of the maternity services, then initiate capacity building together with the hospital management, the gynaecologist in post and the current midwives plus relevant community staff. A lay (non-medical) member of the team, ideally a recent user of the maternity services, should be invited to participate in this process.</li> <li>• At least two long term midwives should be recruited to maintain appropriate cover of the service.</li> <li>• Midwives who have not been 'off island' for recertification or refreshing should be assisted to do so. This should be an essential requirement at least once every three years for all midwives resident on St Helena. In the intervening years, the possibility of distance provision of updating using electronic resources with issuing of certification should be completed by all potentially involved in managing obstetric emergencies.</li> <li>• Improvements continue to be required in the systems in place for theatre management including familiarity with instruments not in frequent use, clarity about what instruments are available and where they are stored, and regular checking of all instruments to organise timely repair or replacement. A short term consultant should be recruited to assess the systems in place in theatre and support local management to improve governance in the theatre setting.</li> <li>• Encourage and document discussion with independent specialists on cases being considered for referral off island.</li> </ul>			
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		<ul style="list-style-type: none"> <li>• Develop stronger links with one or two UK NHS Trusts which will facilitate patient management through case discussion and, hopefully, exchange visit opportunities for staff.</li> <li>• Explore setting up a simple telemedicine service with the twinned hospitals in the UK.</li> <li>• Continue to find ways to engage the community in receiving and acting on better health knowledge and self-help/healthy life style initiatives.</li> <li>• Prioritise the reintroduction of regular CPD activities for all healthcare staff.</li> <li>• Ensure that all joining medical personnel know how to access the local guidelines and protocols as well as the UK guidelines provided by NICE and SIGN to further their knowledge based professional development and to ensure continuity of management approach of patients, using evidence based practices.</li> <li>• Explore obtaining a subscription for the internet resource “Up to Date” – or other evidence based medical information.</li> <li>• Procure a new mannequin for neonatal resuscitation demonstration and ensure that it is regularly used as part of an agreed protocol on neonatal resuscitation training to involve all who may be called upon to assist in a ‘live’ clinical situation.</li> <li>• Provide training on use of the new equipment and ensure regular practice sessions to maintain competencies in their use due to the low requirements of actual clinical use of such items.</li> <li>• If it is not too late, I strongly recommend that the delivery room is located on the same floor as the operating theatre.</li> <li>• The temperature of the delivery room should be closely monitored and ensured to be at the recommended level of 25 to 28 Celsius whenever a woman is admitted in labour.</li> <li>• Babies should not be taken out of the delivery room for weighing and dressing. The scales should be brought into the room for that purpose, then removed and cleaned after use.</li> <li>• Following a thorough overhaul of the current delivery room contents, a check list of all items to be kept in the delivery room should be developed and regularly referred to; this includes the contents of emergency boxes for management of haemorrhage and eclampsia.</li> </ul>			
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		<ul style="list-style-type: none"> <li>• A fully kitted out resuscitation trolley should be close by outside the delivery room. It should have a laminated list of all contents to facilitate checking and restocking.</li> <li>• There should be no medications kept in a locked cupboard in the delivery room; all should be immediately accessible for use.</li> <li>• The existing ventouse system should be declared not fit for use. As there are so few assisted deliveries, it is recommended that a supply of single use vacuum extractors is procured, such as the Kiwi system.</li> <li>• A portable ultrasound machine should be available for use in the delivery room.</li> <li>• The switch for alerting midwifery/nursing staff requires transforming into a more accessible system, e.g. a switch attached to a cord that can be left in easy reach of the patient.</li> <li>• The area of flooring around the existing couch should be covered by a washable material such as good quality vinyl.</li> <li>• Rethink the location of the gynaecologist's consulting room, especially if colposcopy (diagnosis and treatment) is, as earlier recommended, to be moved out of the operating theatre.</li> <li>• If the gynaecologist is to continue to consult from CHC, the flooring around the examination couch needs to be replaced with a durable washable material.</li> <li>• Consider moving the working base of the midwives to the Community Health Clinic to enable them to focus on the healthcare needs of women and their babies, in closer collaboration with the community nurses and care assistants.</li> <li>• If colposcopy procedures are to be performed in the Community Health Clinic, a suitable examination chair will need to be procured and the room should then be dedicated to use by the gynaecologist. The present examination couch should remain as patients sometimes need to recover following out-patient gynaecological interventions.</li> <li>• Procure a portable ultrasound machine for use in the gynaecology consulting room and the delivery room.</li> <li>• Proceed as soon as possible with the creation of new surgical and diagnostic facilities, incorporating a delivery room into the development at the same time.</li> </ul>			
<p>JT Hospital Complex Services</p>					

Jan 2013				
OTD Advisor (TBC)				
Consultant ENT		<ul style="list-style-type: none"> <li>• Primary care treatment pathways for the most common ENT problems with an emphasis of comprehensive primary care management.</li> <li>• Public health promotion to educate about chronic allergic rhinitis; causes, effects and best use of medication for treatment AND prophylaxis.</li> <li>• Develop a strategy for local healthcare staff to perform simple audiometry, and perform a basic fit of a small range of standard hearing aids with remote advice as necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• Recruit a trainer from Siemens to come to the island to train staff in making moulds, fitting the aids and tuning the aid to the required frequency.</li> </ul>	
		<ul style="list-style-type: none"> <li>• To host discussions with the Island legislature about appropriate noise exposure protection measures for workers: both employer duties and worker education with remote input if required.</li> <li>• Plan future visits to anticipate the need to perform minimum 15-20 hearing tests over the 2 week period, to happen alongside the ENT clinic consult.</li> <li>• Visiting specialists to receive 1-2 hour training on EMIS prior to arrival, to cover navigation of electronic record, viewing previous consults, investigations and attachments, prescribing medication, and entering clinical consult information. ENT Visit to St Helena 21</li> <li>• Medical equipment brought from the UK on future visits to include instrument trays to perform simple middle ear surgery, and laryngoscopy &amp; pharyngoscopy.</li> <li>• Consider investing in adult and paediatric bronchoscopy equipment</li> </ul>		

		<p>set, to include appropriate foreign body removing forceps and long suckers.</p> <ul style="list-style-type: none"> <li>• Specialists visiting the island should give regular programme of lectures covering several key topics across the speciality.</li> <li>• A robust educational strategy for future specialist visits: GP's to have the opportunity of at least 2-3 teaching clinics each, and a regular programme of lectures covering several key topics across the speciality.</li> <li>• To introduce two medications to the formulary and stock. To stock an alternative 2nd line nasal spray e.g. Mometasone. To stock 'Flixonase nasules': a fluticasone preparation in drop form.</li> <li>• To consider innovative approaches to GP recruitment as part of the ongoing development of medical services.</li> <li>• To implement public health campaigns and other inputs to planning sustainable models of delivery, potentially using ENT learning from this visit as an indicator speciality.</li> <li>• Future specialist visits should incorporate a comparable clinical governance framework covering the areas of specialist equipment &amp; pattern of care to be expected and provided (over and above core requirements considered as standard for safe and appropriate delivery of healthcare).</li> </ul> <p>Note the body of this report indicates how the recommendations could be achieved, however further information and advice on these can be</p>	<ul style="list-style-type: none"> <li>• We always request specialists to provide training sessions during their visits.</li> <li>• Mometasone has been introduced. Flixonase nasules are stocked and Doctor Hilton prescribed them during his visit, so not sure why this was a recommendation.</li> </ul>		
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		provided if required.		
<b>School of Nursing</b> Cost Benefit Analysis Study		<p><u>Effectiveness of the current school of nursing provision</u>  <u>Recommendations:</u></p> <ul style="list-style-type: none"> <li>• The school of nursing should continue to provide an excellent nursing programme for students and facilitate stimulating professional development programme for qualified nurses.</li> <li>• Mentors should continue to provide an effective skills teaching and mentoring role in the supervision of students in clinical practice. The mentoring refresher update should continue at least once a year to clarify any misunderstandings and to ensure a strong effective mentoring role.</li> <li>• A further in depth study is required on island with ex qualified nurses to explore more fully the reasons why so many have left the profession and to ascertain if under more appropriate conditions and challenges they would return.</li> <li>• A strong consideration must be given to the career pathway and goals of current qualified nurses in as far as possible, by providing them with more flexible and stimulating posts. This may help to retain them in service on Island.</li> </ul> <p><b><u>Cost Effectiveness of the Nursing Programme on Island.</u></b></p> <p><u>Recommendations:</u></p> <ul style="list-style-type: none"> <li>• It is not cost effective to close the School of Nursing on Island. The current method of training students to Diploma level for St Helena nursing service should be sustained.</li> <li>• The intake of students should be increased to 10 over 3 years. This will be more cost effective in relation to providing more local staff nurses to meet the projection needs of the service and recruitment of fewer overseas qualified support nurses.</li> <li>• Students should be encouraged to 'top up' their diploma qualification to degree level by enrolling on to the programme suggested by</li> </ul>		

		<p>Letterkenny Institute.</p> <ul style="list-style-type: none"> <li>• There should be a strong emphasis now (2013) on focusing on the future teaching requirements for the school when the current nurse teacher retires possibly within the next 10 years. The cost of training may be considerable and this will need to be factored into the overall budgeting for sustaining and running the school in the future.</li> <li>• One way to keep the financial costs to a minimum, would be if a local nurse who already has a degree or will have one in the near future were to be identified for registration on to a Post Graduate Certificate/Diploma in Education Programme. This is a similar process to that of the current nurse teacher. The study has identified that student retention is stronger when taught by a permanent resident St Helena nurse teacher.</li> </ul>		
Use of <b>EMIS</b> PCS, Benchmarking, Data & UK Targets – Report 1				
Interim <b>Social Services</b> Trainer		<ul style="list-style-type: none"> <li>• In order for current and future Social Care Officers to consolidate their practice knowledge and capabilities the Directorate could give consideration to the development of a Social Work qualifying programme on the Island with registration to practice at the completion of the programme. In the longer term this could allow the Island to become self-sufficient in Social Work practitioners and provide a career pathway to retain staff.</li> <li>• In relation to Looked After Children, a Permanence Policy should be devised and children looked after by the Directorate should have as part of their review process a clear plan orientated toward a pathway to permanent care.</li> <li>• Adoption practice should be developed to include the approval and implementation of Regulations that govern practice and establishes an Adoption Panel or the equivalent, creating a context that demonstrates due process in adoption decision-making. Further training should be offered to management and practitioner staff in relation to permanency planning and adoption work.</li> </ul>		

		<ul style="list-style-type: none"> <li>Continued effort should be geared towards the cultivation of foster care, and payment to approved foster cares should be considered.</li> <li>A disabled child who lives on a permanent basis away from home in accommodation provided by the Directorate should be identified as a Looked After Child under Section 31 (1) (b) and regarded as accommodated under Section 32 (1), and have in place a care plan to be reviewed under the Looked After Children arrangements as set out at Schedule 2 of the Welfare of Children Ordinance.</li> <li>Practitioners and managers should continue to incorporate the principles of the social model of disability in revising services and planning new ones.</li> <li>Counselling and psychotherapy services should continue to be developed within a strategic planning context and be an intervention delivered by Social Care Officers as part of their repertoire, where appropriate, as well as being delivered by other relevant professionals.</li> <li>Supervision is essential in term of support, development of professional practice and accountable practice and links the practitioner with management on a regular basis. It should not be cancelled except for exceptional reasons and be rescheduled within 48 hours.</li> <li>The Safeguarding Children's Board is a statutory body established by Section 38 of the Welfare of Children Ordinance. It meets on a regular basis, as determined by its Regulations. Because of its important statutory role in the safeguarding of children it should not be cancelled except for exceptional reasons and be rescheduled within 48 hours.</li> </ul>			
Visiting <b>Ophthalmologist</b> Eye		<ul style="list-style-type: none"> <li>Increase effort to keep surgical instruments and equipment in best possible workable state. Train personnel to expect handling of equipment routinely with greatest care. Storing of equipment is following manufacturer recommendations.</li> <li>Continue to support excellent Optometry service. Send Optometrist for Biometry IOL MASTER 500 training at Carl Zeiss Ltd Cambridge (1 full working day) and local NHS trust Department of Ophthalmology using Biometry IOL Master 500 (2 full working days).</li> </ul>			

		<ul style="list-style-type: none"> <li>• Biometry machine IOL master 500 to be unpacked and started by Optometrist with technician Larry Frances (allow 2 full extra days in Optometrist time schedule on arrival before first time use of Biometry for unpacking, assembly, start and test of IOL Master 500.)</li> <li>• Operating Microscope should be unpacked and assembled by Ophthalmologist with help of hospital technician Mr. Larry Frances in 2014.</li> <li>• Request PHSSD to cover costs for 1 day of retraining with OM manufacturer technicians for refreshing my skills how to assemble the OM on SH. I will otherwise have difficulty with correct OM assembly in 2014 visit.</li> <li>• Send Haag Streit Slit lamp Tonometer for calibration test (currently located in white polystyrene container stored around grey plastic suitcase containing Diode laser in white closet in front of sun shade masked window in basement large outpatient clinic room facing south east). Acquire basic Haag Streit tonometer applanation head holder for easier disinfection. See recommendation in text on equipment recommendations above. Acquire angled micro suction probe for aspiration system in OT and micro forceps cauter to aid cauterisation of small blood vessels in possible future Dacryocystorhinostomy procedures.</li> <li>• MO Colleagues kindly to repeat prescriptions until next ophthalmologist examination. Stress importance of continuation of daily glaucoma therapy to prevent visual loss to Glaucoma patients.</li> <li>• Continue best possible supervision and guidance of diabetic patients in diabetic clinics including routine fundus photography of both eyes ideally performed by experienced photographer Bridget Henry.</li> <li>• Consider supporting also motivated nursing officers from SH for work experience and additional training in tertiary care centre abroad.</li> <li>• Consider further educating motivated auxiliary staff (Mrs Bridget Henry) in evaluation and staging of diabetic retinopathy on basis of ocular fundus photography pictures.</li> <li>• List of Phaco machine consumables / disposables will be supplied before end of year 2013 together with other necessary materials for</li> </ul>			
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		next visit in 2014.		
Visiting <b>Ophthalmologist Eye</b>		<ul style="list-style-type: none"> <li>• Medical officers kindly to check patient's eye therapies compliance and to repeat prescriptions until Ophthalmologist patient review.</li> <li>• Continue to stress importance of continuation of daily glaucoma therapy to prevent visual loss to Glaucoma patients.</li> <li>• The Optometrists referral lists should reach the Ophthalmologist as usual in time to enable purchase of surgical consumables and medications.</li> <li>• List of disposables, medications, microsurgical instruments recommended for next Ophthalmology visit should be supplied by Ophthalmologist after receiving patient referral "Eye surgery and clinic patient forecast" by Optometrist before next visit.</li> <li>• Organize one ink cartridge for the ocular biometry results printer in order to print out the intraocular lens calculation results of suggested lens powers for each patient scheduled for Cataract Surgery in future.</li> <li>• Listing of all instruments and equipment with storage location of instrument containers, boxes is a goal worth achieving for the future.</li> <li>• One week visiting time of the Ophthalmologist should be considered to allow for provision of training sessions and equipment instrument inventory storage list.</li> <li>• Ensure maintenance of existing equipment by visiting hospital equipment engineer.</li> <li>• High quality titanium steel microsurgical instruments: micro forceps, lens diallers, micro scissors to replace worn instruments</li> <li>• One Monitor Screen to be attached to Operating microscope would allow nursing staff to follow eye surgeries in detail</li> <li>• Acquire one quality angled suction probe of small diameter for the aspiration system in OT and one micro forceps cauter to aid cauterisation of small blood vessels in possible future tear duct surgeries, Dacryocystorhinostomy procedures.</li> <li>• Order 5 spare light bulbs for the slit lamp and for the old operating microscope in the OT.</li> <li>• Haag Streit tonometer (slit lamp mounted) should – must be checked for correct calibration in 2015. Send Haag Streit Slit lamp Tonometer</li> </ul>		



		<p>for calibration test.</p> <ul style="list-style-type: none"> <li>• H&amp;SW to acquire two basic disinfection cups with 3 tonometer head holders for easier disinfection between patients. When not used by Optometrist and Ophthalmologist the tonometer is located in a white polystyrene container.</li> <li>• A low cost small plastic stand holder filled with disinfection solution for applanation tonometer heads would facilitate disinfection of tonometer head after use on each patient.</li> <li>• Single use disposable tonometer heads from Clement Clarke Ltd are used by the Optometrist for measuring ocular pressures. Single use equipment is minimizing risks of patient ocular surface contamination during intraocular measurements at a higher price.</li> <li>• Consider supporting motivated nursing officers from St Helena for work experience and additional training in secondary and tertiary care centre abroad.</li> </ul> <p><b>Useful actions and Ophthalmology equipment purchase to be considered</b></p> <p>The following new equipment would further improve ophthalmic care:</p> <ul style="list-style-type: none"> <li>• <b>Computerized Visual Field analyser-</b> Would improve screening and follow up of visual field loss in glaucoma and other neuropathies. It requires staff who are trained and motivated to operate the visual field machine.</li> <li>• OCT is now standard equipment for retinal diagnosis</li> <li>• <b>New Fundus camera</b> For taking retinal images in higher resolution through small pupil</li> <li>• <b>New slit lamp - Bio microscope of the eye</b> Including adaptor for photo documentation of external ocular structures and anterior segment would further improve distance transmission of findings and diagnosis</li> </ul> <p><b>Eye care literature -</b></p> <p>Up to date reference for medical officers and nursing staff:</p>			
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		<p>Following organisation of practical eye emergency management literature and basic General Ophthalmology books in 2013 visit I did not organise further Ophthalmology books for the hospital library in 2014.</p> <p>I would like to suggest further acquisition of useful Ophthalmology books functioning as desk reference describing basic and most important concepts, especially Ophthalmology atlas with photos of clinical findings and management notes providing clear guidelines in emergency eye care.</p> <ul style="list-style-type: none"> <li>• <b>Recommendation social functioning in Health sector development on St Helena</b></li> </ul> <p>In addition to the essential changes necessary to minimize imperfections in the medical services and hospital infrastructure on St Helena reducing physical pain, reducing physical disability and controlling conditions that are likely to cause death in patients, factors like access to special nursing skills training, hospital equipment engineering skills training, adequate nursing and auxiliary staff income, emotional well being and satisfactory social functioning between hospital staff and the patients treated should be reflected seriously.</p> <ul style="list-style-type: none"> <li>• It would be of practical help if the Ophthalmologist could have a PC in his clinic room in future.</li> <li>• I would like to suggest improvements in the time schedule organisation. Cleaning and disinfecting of all surfaces in the Ophthalmology clinic room in future regularly at the end of the clinic or before arrival of visiting specialist.</li> </ul> <p><b>Recommendation for Glaucoma medications:</b></p> <ul style="list-style-type: none"> <li>• Continue to stock Latanoprost Xalatan® for its efficient intraocular pressure lowering qualities in chronic open angle Glaucoma and for patients with contraindication to <math>\beta</math> – blockers, poor compliance to <math>\beta</math> – blockers medication.</li> <li>• Continue ordering Bimatoprost Lumigan® and Bimatoprost with Timolol Ganfort® recently prescribed in advanced Glaucoma cases</li> </ul>		
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		<p>with necessity for improved intra-ocular pressure control (see patient records Emis).</p> <ul style="list-style-type: none"> <li>• Advise to stock Brinzolamide Azopt® as adjunct therapy in Glaucoma cases where dual therapy does not achieve satisfactory ocular pressure control.</li> <li>• Continue to stock of Timolol or Timoptol 0,25 % and Timolol or Timoptol 0,5 % as baseline therapy in patients with open angle glaucoma and no contraindication for β – blockers. Do not dispense β – blockers in bradycardia, heart block, uncontrolled heart failure.</li> <li>• Review eligible patients for registration as sight impaired. All advanced to end stage cases of Glaucoma, AMD and other significant eye pathologies with relevant loss of vision should be evaluated for prescription of LVA low vision aids and offered social services support and registration as sight impaired / partially sighted or severely sight impaired / blind.</li> <li>• In future, all referring Medical officers are to include the following information into referral to Ophthalmologist:</li> </ul> <p>Patient's name  age or DOB  eye Hx.  R or L eye involved signs  subjective symptoms  copy of previous Emis entry  digital fundus camera image documentation of patient's retina and papilla optic nerve head</p> <p>A systematic referral letter including the above information in every referral would be most useful to aid me in distance diagnosis and treatment advice, and / or indication for med vac to Cape Town Ophthalmologist.</p> <p><b>Recommendations Ophthalmology equipment and disposables</b></p>		
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		<p><b>Advice on necessary supplies, pharmaceuticals, surgical disposables, instruments, intraocular lens implants in future.</b></p> <p>Short term eye clinic use, pre-, intra- and postoperative medications may warrant change according to current BNF and Royal College of Ophthalmologist recommendations. Medications in use before-, during- and post eye operations are similar antibacterial and anti-inflammatory preparations for variety of eye operations.</p>		
<b>Audits</b>				
Report on Clinical audits on all of the directorates sections. 2013 - 2014				
Internal Audit – <b>H&amp;SS</b> Jul 2014				
Audit – VFM report on <b>Pharmacy</b> Oct 2013				

## 6. Workforce Planning

The Directorate continues to face a number of significant challenges including an increase in lifestyle related illnesses such as hypertension, diabetes, heart disease, cancer and renal failure, an increase in vulnerable adult population (including elderly) requiring specialist care and support while the imminent air access requires strengthening of public health and emergency preparedness. Following agreements made in the last Strategic Plan the current facilities are being developed which will have a considerable health benefit and will aid better and timelier clinical decision making as well as reducing the numbers of patients who will have to be sent overseas. However, whilst there was a delay in the planned refurbishment of the hospital which had an impact on the Medical Treatment Overseas budget line there was still the need to request additional in-year funding of £500K. It is clear that the airport will assist in improving healthcare delivery on island, such as bringing in more specialists, however, it is equally clear that we will need to bring in the services of a dedicated aeromedical evacuation service, which in itself will cost approximately an additional £500K. This situation cannot continue as finances are finite; there therefore needs to be a new policy of rationing healthcare, probably based on the Quality Adjusted Life Years (QALY) model. This is bound to be problematic and controversial

however, it is an equitable and transparent decision-making tool. The introduction of such a model also emphasises the need for the public to take better control of their health and to actively engage in such campaigns such as smoking cessation, exercise and similar to reduce the significant problem of obesity/morbid obesity on the island.

To take forward such improvement of services however directly relates to the clinical ability of the staff as well as appropriate numbers of staff to provide direct patient care. This strategic plan cannot be taken forward unless both of these issues are addressed. There is the direct need to train local staff to the required competency standards and, without any training vote or monies this currently seems to be an almost insurmountable task. A welcome move last year was the transfer of the School of Nursing to a site in the hospital and the development of IT facilities that allow for healthcare staff to access the specialist internet search engines for examples of research and evidence-based practice. This initiative will need to be monitored and taken further forward. Whilst there has been an initiative to potentially link into Schools of Nursing in RSA this needs to be taken further forward. It is important to note that healthcare staff need knowledge, skills and experience and experience can best be served by exposing, in a controlled manner, local staff to busy clinical areas where their learning needs are identified and managed.

Comprehensive healthcare governance needs to continue to be embedded as does risk management however, whilst the last 12 months have seen significant positive growth in these areas there is still some way to go and there is no room for complacency. We continue to be unable to obtain reliable and accurate data collection which is a fundamental requirement that has to occur to ensure that information can be analysed and turned into intelligence to take the health service forward.

The vision for the Health Service for 2020 and beyond is to provide a quality community health and social care service and an integrated primary and secondary health care service which focuses on pre-emptive measures to improve the health of the island community. This is fully in keeping with the agreed outcome for Health as set out in the island's Sustainable Development Plan (SDP) where "life expectancy is increased and healthy lifestyles are promoted".

In order to achieve these points above a number of activities will need to take place during the next three years. These activities are interrelated and include:

- Training and up-skilling of local staff to achieve agreed sets of competencies
- Implementing a programme which emphasises a community/collective approach to address the health of the island.
- Continue with implementing a system of healthcare governance and risk management which creates an environment in which

excellence in clinical and health care will flourish.

- Imbedding the Egton (electronic) Management Information System (EMIS) to ensure that relevant and reliable data is captured and incorporates a Quality Outcomes Framework (QOF) that articulates and quantifies patient clinical outcomes.
- More accurate data analysis so that trends can be identified and resources more accurately targeted and prioritised.

As stated above, in the medium to longer term, it is envisaged that there will be new purpose built integrated healthcare provision, with a new hospital as the central hub, which will adequately provide for the needs of the community as the island develops and its population grows.

Key to achieving this vision will be a greater focus on improving the skills and competencies of staff across all of the Health Services. Although it is recognised that this will take some time to progress to appropriate competency levels it is envisaged that in addition to local and overseas training this will be achieved through:

- Continuing the introduction of set clinical competencies which staff will be supported to achieve.
- Talent management and succession planning strategies to recognise staff with potential and facilitate the grooming of such staff for future promotions within the directorate.
- Continue with the development of the current School of Nursing, with its current focus of pre-Registration nurse training, to a wider remit of post-Registration/Graduation Health Education Centre and the use of blended E-learning and external exposure to learning opportunities.

It is envisaged that as staff become more competent and qualified, the potential for reducing headcount will increase. Midwifery will be a particular area of focus during 2015, for up-skilling and increasing support.

TC support will always be needed in Health for the foreseeable future; in the short to medium term the need for TC will increase above the current level in order to provide training as outlined above and also to address some crucial staffing gaps.

This Plan, whilst focusing on the continued delivery of our core functions works towards the implementation of key activities to enhance our ability to provide the best possible service within available resources. The priority focus for Health over the next three year budget and beyond will be to continue to articulate the clinical standards, competencies and services required to improve an integrated primary and secondary health care, which will in turn improve the quality of health on the island. It is important to keep these longer term goals in mind when allocating

resources, especially when we think of the overall benefits of (i) encouraging St Helenians to return to the island to live and work, (ii) increasing the number of tourists who visit the island (who will also expect a reasonable level of health care) so that through (iii) economic development, the island can ultimately reduce its reliance on aid funding.

This plan is ambitious and there will many challenges ahead but with continued support and teamwork I am confident that the staff in the Directorate will meet all of our targets for the next 3 years.

**SECTION 2 DETAILED ACTION PLANS – Performance information will be required on a monthly basis for the Business Delivery Group and Appropriate Committees.**

<b>DIRECTORATE: Health &amp; Social Services</b>							
<b>SECTION: Community Care</b>							
<b>SHG Goal: Strong Community and Family Life</b>							
<b>Strategic Objective: 2.1 - Health care improved as a result of greater investment in primary and secondary health facilities</b>							
<b>Sub-Objective:</b>							
<b>Directorate/section objective</b>	<b>Performance Measure/Success criteria (Indicator)</b>	<b>Baseline</b>	<b>Target (Year 1)</b>	<b>Target (Year 2)</b>	<b>Target (Year 3)</b>	<b>Output/s for Appropriation</b>	<b>Responsible person(s)</b>
	<b>Vaccination Coverage</b> (Children at 2 years of age, up to date with vaccinations). Health care improved as a result of greater investment in primary and secondary health facilities	31 two year olds, 93.5% of the total population	100%	100%	100%	Follow the recommended UK immunization schedule  Arrange Childhealth appointments monthly in accordance to schedule.  Health promotion awareness of immunizations  Issue all parents with a copy of the child health record books  <u>Primary facilities</u>  Staff training for community nurses in emergency care, EMIS data Searching.evidence based	Community Officer    Nursing Officer



						<p>practice and specialist nursing e.g childhealth, palliative care, gynaecology to improve the level of knowledge &amp; skills.</p> <p>Up grading of consultation rooms with vital sign monitors to reduce the waiting time and allowing the practice nurse time for dressing's and nurse lead consultations</p>	
	<p><b>Obesity</b> Reduce the number of people that are clinically obese. Reduce rates of hypertension, diabetes and obesity by encouraging healthy behaviours and lifestyle choices.</p>	<p>EMIS Population 3034, BMI EMIS Population 169, Percentage TBC to reflect true BMI status.</p>	<p>Baseline % of obese and % of morbidly obese patients</p>	<p>TBC% obese TBC% morbidly obese</p>	<p>TBC% obese TBC% morbidly obese</p>	<p>Health education activities (Diet menus, Radio talks, newspaper articles,  Bi- annual workplace screening  Height, weight, BMI Monitoring for inpatients, outpatients &amp; school age children.  Improve use of Gym facilities for adults &amp; senior citizens that can provide Exercise/keepfit, slimming class,  Engage organisations to provide sports e.g cricket &amp; football &amp; womens associations to provide day/evening sports,  Encourage development of sports &amp; fitness through Primary &amp; Secondary school curriculum.</p>	<p>Community Nursing Officer</p>
	<p><b>Diabetes</b> % of diabetics with HBA1C ≤ 7.5 on their last test. Number of patients</p>	<p>EMIS Population 3034, Diabetic EMIS Population 693,</p>	<p>40% EMIS status  10% patients with HBA1C ≤7.5 and below</p>	<p>55% EMIS status  25% patients with HBA1C ≤7.5 and below</p>	<p>65% EMIS status  35% patients</p>	<p>6 monthly venous sampling  Health education on diet &amp; glycaemic control</p>	<p>Community Nursing Officer</p>

	admitted with a diabetes related complication. Reduce rates of hypertension, diabetes and obesity by encouraging healthy behaviours and lifestyle choices.	693/4500 = 15.4% 3.03% patients with HBA1C £7.5 and below. 3.75% patients above 7.5.	3% patients above 7.5.	2% patients above 7.5.	with HBA1C ≤7.5 and below  1% patients above 7.5.	Diabetic clinic appointments, 3 or 6 months depending on previous level  To set up recall system on EMIS  Improve glycaemic control 1 <sup>st</sup> line treatment – diet + Tablets or 2 <sup>nd</sup> line treatment –diet +,tablets+ insulin to reduce the risks of longterm complications  Monitor hospital admissions and reasons and put action / treatment plans inplace for prevention of reoccurrent admissions.  <b>Sames as obesity management + treatment compliances</b>	
	<b>Hypertension (HT) care/treatment</b> % hypertensives with a blood pressure ≤140/90 in the last year – last measurement only		75%	80%	80%	To provide EMIS data search monthly	Community Nursing Officer/ Cardiac nurse
	<b>Mental Health care</b> Number of acute mental health admissions per year. Health care improved as a result of greater investment in primary and secondary health facilities.	1.55% Mental Health patients of total population.  5 Mental Health Admissions per year.	4 Mental Health Admissions per year.	3 Mental Health Admissions per year.	2 Mental Health Admissions per year.		Community Nursing Officer/Community Psychiatric Nurse
	<b>Cervical cancer</b> % of women 20-65 years who are up to date with their smear test.	Baseline TBC  46%	60%	70%	75%	To provide EMIS data search monthly or monthly reporting from the gynaecology nurse	Community Nursing Officer

	<p><b>Colon cancer</b> % of men/women 50 -74 years who completed 3x faecal occult blood (FOB) test during the past 2 year.</p>	<p>Baseline TBC 0%</p>	25%	50%	80%	<p>To provide EMIS data search monthly or monthly reporting from the Oncology Nurse or path Lab</p>	<p>Community Nursing Officer</p>
	<p><b>Smoking</b> % of clients who have received counselling for smoking and who have stopped. Reduce rates of hypertension, diabetes and obesity by encouraging healthy behaviours and lifestyle choices.</p>	<p>EMIS Population 3034, Smoking EMIS status record 1655, 1655/4500 = 36.78%  Smokers 552/1655 = 33.35%.</p>	<p>70% EMIS status 25% of smokers</p>	<p>85% EMIS status 20% of smokers</p>	<p>95% EMIS status 15% of smokers</p>	<p>Health education on health risk due to smoking &amp; effects of NRT  Regular follow up appointments  Smoking anyalasis using the carbonmoxide measure  Sames as obesity management + treatment compliances</p>	<p>Community Nursing Officer and Pharmacist</p>
	<p><b>Alcohol abuse</b> This will evaluate our dangers of alcohol awareness program.</p>	<p>The % enrolled in counselling sessions who stopped drinking 20% (6/30).</p>	8%	12%	15%		<p>Community Nursing Officer</p>
	<p><b>Care Standards</b> % of patients readmitted to hospital within 28 days. Annual Patient satisfaction survey. This will give an indication of hospital care and social care in the community.</p>	<p>This will give an indication of hospital care and social care in the community.</p>	8%	8%	8%	<p>Ensure that the pts holistic care needs are identified prior to discharge and all relevant care providers are informed of the need for follow-up upon discharge.  Nurse to educate pt/carers on healthy lifestyles/wound care/compliance with prescribed treatment etc &amp; to check understanding.  Every inpatient will be given a Pt</p>	<p>Hospital Nursing Officer</p>

						satisfaction questionnaire & assisted to complete it prior to discharge.	
	<p><b>Antenatal and delivery care</b>                  % of assisted deliveries                  Target ≤ 35%                  These indicators will evaluate the obstetric service delivered.</p>	<p>These indicators will evaluate the obstetric service delivered.</p>	≤ 35%	≤ 35%	≤ 35%	<p>Midwives to address and educate mothers on adverse/high risk health complications e.g diabetes in pregnancy, obesity, smoking/consumption of alcohol during pregnancy etc. and inform parents to be on reasons for possible intervention during delivery.</p> <p>Midwives to plot progress of labour onto the partograms to aid decision making.</p> <p>Midwives to be vigilant in conducting and producing a written report on Peer Reviews for every delivery.</p>	<p>Hospital Nursing Officer/Lead Midwife</p>

**DIRECTORATE: Health**

**SECTION: Medical**

**SHG Goal: Strong Community and Family Life**

**Strategic Objective: 2.1 - Health care improved as a result of greater investment in primary and secondary health facilities**

**Sub-Objective:**

# Operational Plan for Health Directorate/Section 2015-18

Directorate/section objective	Performance Measure/Success criteria (Indicator)	Baseline	Target (Year 1)	Target (Year 2)	Target (Year 3)	Output/s for Appropriation	Responsible person(s)
	<p>The hospital and its services meet appropriate standards. To redevelop the hospital to address health and safety hazards, including operating theatre and clinical diagnostic suite to support modern, safe and effective health care.</p>	<p>Facilities &amp; equipment not fit for purpose</p>	<p>Operating theatre and diagnostic suite development completed and operational by December 2015</p>	<p>Ongoing monitoring &amp; maintenance as per preventative maintenance programme</p>		<p>Plan regular weekly meetings with project manager/contractors and nursing staff to identify phasing of work, requirements/potential hazards and address them in a timely manner to allow smooth transition of works. Equipment Procurement Committee to process equipment orders as appropriate.</p> <p>Staff to be trained in correct use/storage/cleaning of equipment.</p> <p>Risk matrix to be updated monthly or as necessary.</p> <p>Equipment to be entered onto equipment register and maintained as per manufactures recommendations.</p>	<p>SMO/HNO</p>
	<p>To improve healthcare governance. Develop healthcare governance committee and associated sub-committees of:</p> <ul style="list-style-type: none"> <li>• Equipment Procurement;</li> <li>• Infection Control;</li> <li>• Training;</li> <li>• Medicines Management,</li> <li>• Information Governance;</li> <li>• Audit</li> </ul>		<p>Main Committee and all sub-committees are in place</p> <p>Audit report to SHG SMT by June 2015</p>	<p>Audit report to SHG SMT by June 2016</p>	<p>Audit report to SHG SMT by June 2017</p>	<p>Identify members and TORS for each committee.</p> <p>For the various committees to meet regularly to discuss business. Minutes to be taken of all meetings.</p> <p>Service provision to be audited, action plans agreed and implemented.</p> <p>Identified training for staff to be delivered and progress towards identified action plans to be</p>	<p>SMO/ACHM</p>

	<ul style="list-style-type: none"> <li>Incident reporting and complaints / compliments</li> </ul>					monitored.	
	<p>Appropriate workforce development. To ensure essential human resources for health services are available to deliver quality services to address health/ services needs.</p>	<p>Current staff annual appraisals</p> <p>Competencies agreed and rolled out April 2015</p> <p>School of nursing closed, overseas nurse training programme started.</p> <p>Links to Derby for E-Learning established</p> <p>Training budget established</p>	<p>20% staff meeting required competencies</p> <p>1 student sent overseas for training</p> <p>50% of staff completing additional E-Lerning modules</p> <p>Locum on island trainers/ specialists, access to medical journals/ textbooks,</p>	<p>Training pathways articulated and costed</p> <p>40% staff meeting required competencies</p> <p>2 students sent overseas for training</p> <p>100% of staff completing additional E-Lerning modules</p> <p>Locum on island trainers/ specialists, access to medical journals/ textbooks,</p>	<p>60% staff meeting required competencies</p> <p>2 students sent overseas for training</p> <p>100% of staff completing additional E-Lerning modules</p> <p>Locum on island trainers/ specialists, access to medical journals/ textbooks,</p>	<p>All staff to complete annual appraisals within given timeframes.</p> <p>All identified training needs to be entered onto the SHG HRIS21 system.</p> <p>Introduction of regular study days of which all staff will attend.</p> <p>Development of a yearly Mandatory Training programme</p> <p>Full training records to be kept by HR</p> <p>All training accessed to be evaluated immediately after the session. Implementation of new learning to practice to be monitored and evaluated 6 months then 1 yr post training.</p> <p>Competencies to be signed off by staff member then by the HNO once satisfied that the staff member can consistently demonstrated they are competent in the skill.</p>	<p>Heads of sections/Nurse Teacher</p>
<p><b>DIRECTORATE: Health</b></p>							

SECTION: Dental							
SHG Goal: Strong Community and Family Life							
Strategic Objective: 2.1 - Health care improved as a result of greater investment in primary and secondary health facilities							
Sub-Objective:							
Directorate/section objective	Performance Measure/Success criteria (Indicator)	Baseline	Target (Year 1)	Target (Year 2)	Target (Year 3)	Output/s for Appropriation	Responsible person(s)
	Improved dental health of all school children. To improve dental health of all school children. 100% of children receiving treatment within 4 months of annual screening taking place.	TBC	100%	100%	100%	Dental Services	Resident Dentist
	To fabricate 14 dentures per 5 week cycle. Triage system is in place to prioritise patients. The dental laboratory's production capacity is 14 dentures.	April 2013 waiting list 118 patients April 2014 132 patients	90%	100%	100%	Dental Services	Resident Dentist
	Waiting times for appointments for routine dental patients to be less than 3 weeks. To reduce waiting times for appointments for routine dental patients to be less than 3 weeks.	5 Weeks as at April 2014	70% by 31 March'15	100% by 31 March'16	100% by 31 March'17	Dental Services	Resident Dentist
	Facilitate the overseas training of a local staff member in dental therapy/hygiene	No trained local staff member	Commences overseas training September 2015	Commences 2 year of training	Commences 3 year of training	Completes training by September 2018	Resident Dentist

DIRECTORATE: Health							
SECTION: Pharmacy							
SHG Goal: Strong Community and Family Life							
Strategic Objective: 2.1 - Health care improved as a result of greater investment in primary and secondary health facilities							
Sub-Objective:							
Directorate/section objective	Performance Measure/Success criteria (Indicator)	Baseline	Target (Year 1)	Target (Year 2)	Target (Year 3)	Output/s for Appropriation	Responsible person(s)
	<ul style="list-style-type: none"> <li>Adherence to budget limits.</li> <li>% patients presenting with upper respiratory tract infections prescribed antibiotics.</li> <li>% patients presenting with acute diarrhoea prescribed antibiotics.</li> <li>Monthly spot checks of stock levels in medical store (at least 40 items per month).</li> <li>Cost effective drug use and prescribing that is both rational and evidence based.</li> </ul>	Overspend 2011/12 FY £43,63985% January 2011 57% January 2011 -No spot checks occurring	Expenditure within budget allocation.  <30% March 2015  <20% March 2015  100% of spot checks completed, 100% of discrepancies investigated	Expenditure within budget allocation.  <30% March 2016  <20% March 2016  100% of spot checks completed, 100% of discrepancies investigated	Expenditure within budget allocation.  <30% March 2017  <20% March 2017  100% of spot checks completed, 100% of discrepancies investigated	Pharmacy Services	Pharmacist
1.1 To ensure adequate supply of and appropriate stock levels of drugs	No out of stocks for essential items Wastage from out-of date stocks reduced. Annual stock checks and periodic checks to ensure stock levels are correct against stock control system.	No out of stocks resulting in patient harm during 2013/14  Wastage for 13/14 FY= 3.98%	100% essential item availability  <3.5% wastage	100% essential item availability  <3% wastage	100% essential item availability  <2.5% wastage	Pharmacy Services	Pharmacist



1.2 Correct stock management procedures followed ensuring compliance with Financial Regulations and Internal Audit recommendations.	Access Dimensions updated in a timely manner following all stock movements. Pharmacist checking a sample of stock movement to ensure accuracy.	All stock movements being recorded on Access Dimensions.	All internal stock movements updated within 3 working days.	All internal stock movements updated within 3 working days.	All internal stock movements updated within 3 working days.	Pharmacy Services	Pharmacist
1.2 1.2 To ensure cost-effective drug procurement	Quotations from existing suppliers compared for all bulk orders. At least 3 quotations sought for new additions to the formulary. Possibility of NHS procurement link explored and new suppliers approached as appropriate	Quotes sought on bulk orders or price lists compared. New link-ups continually explored.	At least 3 quotations sought on all new lines and prices on existing lines checked for all bulk orders	At least 3 quotations sought on all new lines and prices on existing lines checked for all bulk orders	At least 3 quotations sought on all new lines and prices on existing lines checked for all bulk orders	Pharmacy Services	Pharmacist
1.3 Develop local guidelines on prescribing where a need is identified	Guidelines written, agreed and implemented as per identified needs	Selected local guidance already in place	100% of identified needs have guideline produced	100% of identified needs have guideline produced	100% of identified needs have guideline produced	Pharmacy Services	Pharmacist
1.4 Conduct audits to assist in delivering safe, appropriate and cost effective prescribing practices	Audits conducted as per audit plan and results discussed with medical team	Regular prescribing audits are conducted, but not always to a set schedule.	100% of audits conducted as per plan	100% of audits conducted as per plan	100% of audits conducted as per plan	Pharmacy Services	Pharmacist
1.5 Support medical officers by updating them on new prescribing information as it becomes available	Ensure all relevant new prescribing information is passed on in a timely fashion to medical officers	E-mail alerting system in place from NICE. Inclusion in NHS Devon prescribing information newsletter distribution.	Pass on all relevant information	Pass on all relevant information	Pass on all relevant information	Pharmacy Services	Pharmacist
1.6 To ensure adequate stock management in the hospital and other locations outside the pharmacy	Pharmacy-assisted ward stock top-up in the hospital	Pharmacist checks ward stocks at least twice weekly	Pharmacy-assisted ward top-up	Pharmacy-assisted ward top-up	Pharmacy-assisted ward top-up	Pharmacy Services	Pharmacist
1.7 Identify and switch suitable patients to mode modern diabetic treatments: Lantus and sitagliptan	Eligible patients offered new treatments	Added to formulary April 2014	100% eligible patients	100% eligible patients	100% eligible patients	Pharmacy Services	Pharmacist

# Operational Plan for Health Directorate/Section 2015-18

1.8 Ensure patients with high levels of polypharmacy are prioritised for medication review	Monitor polypharmacy index  Ensure all patients on 6 or more repeat items have a medication review every 6 months.	4.6% reduction in polypharmacy index 2013-14 FY.  Average 4.15 items per patient per month	Less than 1% rise in polypharmacy index  %patients on chronic medications with medication review coded	3% reduction in polypharmacy index  %patients on chronic medications with medication review coded	2% reduction in polypharmacy index  %patients on chronic medications with medication review coded	There will be slight rise in polypharmacy index initially due to change in way we dispense to institutions i.e. CCC, BV, and CBU.	Pharmacist
1.9 Medicines management committee to contribute to overall healthcare governance	Committee and objectives in place and regular meetings held	Medicines Management Committee formed and in place	At least 4 meetings per annum	At least 4 meetings per annum	At least 4 meetings per annum	Pharmacy Services	Pharmacist
	Number of items sold over-the-counter. Access to over-the-counter medication for minor ailments to promote self-management of minor conditions.	130 items per month (figure from Q2 2013)	200 items per month by March 2015	250 items per month by March 2016	325 items per month by March 2017	Pharmacy Services	Pharmacist
2.1 To raise awareness on appropriate and safe drug use for minor ailments	Leaflets available on minor ailment management and disseminated in appropriate locations	Leaflet series in place at pharmacy	At least 2 leaflets disseminated in public places	At least 2 leaflets disseminated in public places	At least 2 leaflets disseminated in public places	Pharmacy Services	Pharmacist
2.2 To raise awareness of what conditions can be self-treated without seeing the doctor	Appropriate publicity	Promotional material in place in clinic areas. Consider re-running article in newspaper.	1 radio show per annum  1 newspaper article per annum	1 radio show per annum  1 newspaper article per annum	1 radio show per annum  1 newspaper article per annum	Pharmacy Services	Pharmacist
2.3 Referral of appropriate patients from the outpatient nurse to the pharmacist	Appropriate patients are signposted to the pharmacy rather than being booked in for a doctor's appointment	We are not monitoring what % of patients coming to purchase items over the counter are self-referrals and which are from the nurse	Nurse to keep tally of patients referred to pharmacy	Nurse to keep tally of patients referred to pharmacy	Nurse to keep tally of patients referred to pharmacy	Pharmacy Services	Pharmacist
	All staff having achieved a qualification. Audit system in place to reduce dispensing	Zero staff with a qualification No audit system in place No checks on	100% of staff having completed Stonebridge		100% of staff having completed NVQ level 2 in	Pharmacy Services	Pharmacist

	errors. All inpatient drug charts checked by pharmacist. No out-of-stocks for essential medications A safe, efficient and robust dispensing service.	inpatient drug charts (no pharmacist)Unknown	distance learning certificate (March 2015)  100% of errors identified corrected without resulting in patient harm (annual target)  100% of hospital inpatients have drug chart checked by pharmacist (annual target) 0 out of stocks on essential lines (annual target)	100% of errors identified corrected without resulting in patient harm (annual target)  100% of hospital inpatients have drug chart checked by pharmacist (annual target)  0 out of stocks on essential lines (annual target)	Pharmaceutical Services (by March 2017)  100% of errors identified corrected without resulting in patient harm (annual target)  100% of hospital inpatients have drug chart checked by pharmacist (annual target)  0 out of stocks on essential lines (annual target)		
3.1 Structured learning to improve skills set of staff	Completion of Stonebridge course. On the job training as required. Staff enrolled on NVQ2 level course.	2 of 3 staff have completed Stonebridge course	Stonebridge course completed by all staff	Suitable staff enrolled on Pharmacy Services NVQ level 2	Suitable staff enrolled on Pharmacy Services NVQ level 2	Pharmacy Services	Pharmacist
3.2 Pharmacist to keep CPD up-to-date as per requirements of General Pharmaceutical Council	No. of CPD records per year	9 CPD records per year	9 CPD records per year	9 CPD records per year	9 CPD records per year	Pharmacy Services	Pharmacist
3.3 To monitor use of narcotics and controlled substances	Quarterly report on narcotics submitted to INCB	All reports submitted in accordance with deadlines	100% of reports completed and submitted	100% of reports completed and submitted	100% of reports completed and submitted	Pharmacy Services	Pharmacist
3.4 Involvement of pharmacist in preparing, checking	All discharge prescriptions during pharmacy opening	System in place	100% of discharge prescriptions	100% of discharge prescriptions	100% of discharge prescriptions	Pharmacy Services	Pharmacist

# Operational Plan for Health Directorate/Section 2015-18

and counselling on discharge prescriptions.	hours routed via pharmacist		completed by pharmacist during pharmacy opening hours	completed by pharmacist during pharmacy opening hours	completed by pharmacist during pharmacy opening hours		
3.5 Emergency stock kept and rotated to meet requirements of Major Accident Plan (MAP)	All supplies agreed in MAP available.	Up-to-date MAP not in place.	100% of MAP supplies available	100% of MAP supplies available	100% of MAP supplies available	Pharmacy Services	Pharmacist
3.6 To roll out monitored dose systems (MDS) to patients in community with difficulty managing their medication	To supply MDS trays to those patients identified by doctors and community nurses as having difficulty with their medicines management	Available to all patients brought to pharmacist's attention	100% of identified patients on MDS system	100% of identified patients on MDS system	100% of identified patients on MDS system	Pharmacy Services	Pharmacist
3.7 Work with CCC to ensure optimal medicines management processes in place	Pharmacy-filled dosette trays provided.  Visits by pharmacist to check treatment plans.	Pharmacy filled dosette trays currently being rolled out. Pharmacist does visit and review treatment plans at CCC. Set schedule needed.	Pharmacy-filled dosette trays in place  Quarterly pharmacist visit to check treatment plans	Pharmacy-filled dosette trays in place  Quarterly pharmacist visit to check treatment plans	Pharmacy-filled dosette trays in place Quarterly pharmacist visit to check treatment plans	Pharmacy Services	Pharmacist
3.8 Ensure all patients are referred back to the doctor for a medication review once their authorisation has lapsed	All patients having at least one medication review per annum	Some patients have lapsed medicines authorisation	All patients having 1 medication review per annum	All patients having 1 medication review per annum	All patients having 1 medication review per annum	Pharmacy Services	Pharmacist
3.9 Action all relevant MHRA (UK) and MRC (RSA) drug alerts.	Ensure all Class 2 recalls from the MHRA are acted upon within 48 hours	MHRA e-mail alert system has been subscribed to	100% class 2 recalls acted upon	100% class 2 recalls acted upon	100% class 2 recalls acted upon	Pharmacy Services	Pharmacist
3.10 Implement a quality assurance system for extemporaneous preparations	Quality assurance systems written and implemented to ensure our extemporaneous products are of a suitable quality and appropriate records are maintained	No quality assurance system in place	Quality assurance system in place	Quality assurance system in place	Quality assurance system in place	Pharmacy Services	Pharmacist
3.11 To update Pharmacy and Poisons Ordinance	Draft submitted and new ordinance in place	Current ordinance written in 1939	Draft submitted	New ordinance in place	New ordinance in place	Pharmacy Services	Pharmacist

3.12 Additional member of staff to be able implement Internal Audit's recommendations regarding stock control	New stock control system implemented with assistance of temporary member of staff.	No permanent storekeeper for managing stocks with annual budget approaching £500,000	1 FTE member of staff in place.	1 FTE member of staff in place.	1 FTE member of staff in place.	Pharmacy Services	Pharmacist
3.13 Increased checks on dispensing in the pharmacy as a result of a permanent storekeeper as above in 3.12.	All 'acute' and 'high risk' prescriptions second checked by the pharmacist in Jamestown	Acute prescriptions are clinically checked in Jamestown but not always accuracy checked due to inadequate staffing	New SOP written and system in place	New SOP written and system in place	New SOP written and system in place	Pharmacy Services	Pharmacist
3.14 Preparation and disposal of IV chemotherapy in accordance with accepted standards on island	IV chemotherapy only to be administered on-island when suitable equipment and staff training are in place	No IV chemotherapy offered on island	New procedure researched and agreed upon	New procedure implemented as agreed	New procedure implemented as agreed	Pharmacy Services	Pharmacist

**DIRECTORATE: Health**

**SECTION: Laboratory**

**SHG Goal: Strong Community and Family Life**

**Strategic Objective: 2.1 - Health care improved as a result of greater investment in primary and secondary health facilities.  
2.2 - Improved primary and secondary health care as a result of better qualified staff.**

**Sub-Objective:**

Directorate/section objective	Performance Measure/Success criteria (Indicator)	Baseline	Target (Year 1)	Target (Year 2)	Target (Year 3)	Output/s for Appropriation	Responsible person(s)
	Lab turn-around-times for testing meets agreed targets To improve effectiveness and	Turn-around-times (TAT) for emergency and routine requests in clinical lab.				Laboratory services	Lab Manager

# Operational Plan for Health Directorate/Section | 2015-18

	efficiency of the laboratory	1. TAT emergency requests within 45 min. Baseline 95% 2. TAT routine requests within 24 hours Baseline 90%	98%  95%	98%  95%	98%  95%		
	Equipment serviced as per agreed maintenance schedule. Equipment requires regular maintenance and in addition to the daily maintenance carried out by staff, a more comprehensive annual service is needed by a qualified biomedical engineer.	All equipment serviced and new equipment in place.	Annually	Annually	Annually	Laboratory services	Lab Manager
	ISO 17025 accreditation status retained Status required to support fish export industry and other food & water testing.	Accreditation status of Food Lab maintained and expanded to include Listeria monocytogenes.	Pass all annual assessments	Pass all annual assessments	Pass all annual assessments	Laboratory services	Lab Manager
	Facilitate the overseas training of a local staff member in biomedical sciences	No trained local staff member	Commences overseas training September 2015	Commences 2 year of training	Commences 3 year of training	Completes training by September 2018	
	Improved safety and range of blood products available for patient care	Forge links with a UK Blood Transfusion Service to provide products when airport is functioning.	No products acquired from UK BTS.	90% of products acquired from UK BTS	100% of products acquired from UK BTS.	Laboratory services	Lab Manager

**DIRECTORATE: Health**

SECTION: Environmental Health							
SHG Goal: Strong Community and Family Life							
Strategic Objective: 2.1 - Health care improved as a result of greater investment in primary and secondary health facilities							
Sub-Objective:							
Directorate/section objective	Performance Measure/Success criteria (Indicator)	Baseline	Target (Year 1)	Target (Year 2)	Target (Year 3)	Output/s for Appropriation	Responsible person(s)
	To improve compliance with International Health Regulations	Compliance with IHR	Updated Port Health legislation in place by 30 April 2015  Ongoing monitoring for compliance (UK HPA review)	Ongoing monitoring for compliance	Ongoing monitoring for compliance	<b>Enviornmental Health</b>	SEHO/EHO
	To ensure High Quality Drinking Water	New Legislation adopted and adhered to	By Dec 2015  (annual audit water sampling & testing data)	Review complainace December 2016  (annual audit water sampling & testing data)	Stakeholders consulted; HPB : HSWC by April 2017  (annual audit water sampling & testing data)	<b>Enviornmental Health</b>  Legiislation in place by April 2016  (annual audit water sampling & testing data)	SEHO/EHO
	To improve hygiene and food safety standards in food establishments	Updated Food Hygiene Regulations enforced  Food ordinance	By Dec 2015 for complete revised Food legislation	Review complainace December 2016	Stakeholders consulted; HPB : HSWC by April 2017	<b>Enviornmental Health</b>  Legiislation in place by April 2016	SEHO/EHO

		developed and adopted  Slaughterhouse regulations updated  Annual audits show compliance with regulations	(annual audit sampling & testing data)	(annual audit sampling & testing data)	(annual audit sampling & testing data)	(annual audit sampling & testing data)	
	To improve health and safety in the workplace (private/government)	Health and Safety Ordinance and Regulation updated  Workplaces complied with health and safety standards	By March 2015  30% workplaces audited by March 2016	Information gathering for updating the Legislation by march 2015	Redrafting of legislation by 2016	<b>Enviornmental Health</b>  Implementation of new legislation by 2017	SEHO/EHO
	To improve cost-efficiency of Public Health pest Control Service on the Island	Pest Control Services divested					SEHO/ADMIN
	To ensure Health Protection Board is fully informed and involved on progress and strategic decision making with respect to implementation of Fish and Fish Products Ordinance 2010 and the enforcement of the International Health Regulations		4x/year (annual target)  Minutes disseminated	4x/year (annual target)  Minutes disseminated	4x/year (annual target)  Minutes disseminated		Health Board /SEHO Protection Secretary

### SECTION 3 OPERATIONAL RISKS

The following (at ANNEX A) operational risks for the Health Directorate link the raw risks and their potential impact and probability to actual and potential mitigation activities. The resultant post-mitigation operational risks are reviewed by an internal risk panel that sits quarterly and is



made up of senior health managers. Then, where appropriate, these risks are taken to SHG BDG for further analysis in line with other SHG operational risks. This process allows risks to be identified and managed at an appropriate level.

### Appendix A

No	Sections	Serial	Risk Description	Issue Impact / Probability		Status (RAYG)	Potential Mitigation Description	Residual Issue Impact / Probability		Residual Status (RAYG)	Department Action Responsibility <sup>1</sup>
				I	P			I	P		
		(a)	(b)	(c)		(d)	(e)	(f)		(g)	(h)
1	Acute & Community	A2	Patient care and safety compromised due to insufficient no's. registered nurses	5	5	Red	Community nurses rotated to cover shifts in hospital Employ retired nurses on temporary contracts Reduce no. specialists clinics to free nurses to cover shifts Employ TC nurses HNO cover some shifts	2	3	Yellow	DHSW/ACHM
2	Acute & Community	A21	Risk of morbidity of administering doctor and general public due to lack of proper facilities and training to provide IV chemotherapy as well as lack of proper chemo waste disposal. <ul style="list-style-type: none"> <li>• Within 6 months</li> </ul>	5	5	Red	Proper waste management. Training of doctor/pharmacists in RSA. Special cabinet to contain the chemo.	3	3	Amber	SMO
3	Acute & Community	Corp1	Risk of cross infection between colleagues/service users leading to mortality/morbidity due to	5	5	Red	Include HIV, Hep B, TB, and MRSA screening and recruitment. Policy to be developed by HR.	2	2	Yellow	SHG/K Worboys

# Operational Plan for Health Directorate/Section 2015-18

			failure to screen healthcare personnel for HIV, TB, Hep B and MRSA.								
4	Acute & Community	C1	Patient care and safety compromised due to insufficient no's. registered nurses	5	5	Red	Community nurses doubling up to cover workload Employ retired nurses on temporary contracts Reduce no. specialists clinics to free nurses to cover workload CNO cover some districts ACHM to work in districts in event of staffing crisis	2	2	Yellow	CNO
5	Acute & Community	A&C1	Litigation and pt morbidity/mortality due to unreliable electronic record keeping system	5	5	Red	Upgrade system or replace with a system fit for purpose Appropriate TC support Recruit a trainer to train a local person to manage the system	2	2	Yellow	DHSW
6	Dental Services	D5	Increased morbidity as a result of incorrect disposal of hazardous waste.	2	5	Red	To formulate procedures for the safe disposal of : Amalgam Lead Spent developing and fixative x-ray chemicals Installation of amalgam separators at suction units.	1	1	Green	DSW, SDO, DO, CD
7	Dental Services	D6	Increased patient morbidity as best practice HTM 01-05 (cross infection control/decontamination of dental practices) guidelines are not implemented.	4	3	Amber	To have funding made available to implement HTM 01-05	1	1	Green	DHSW,SDO,DO
8	Dental Services	D7	Washer/disinfector required to streamline sterilization of instruments as per best practice recommendations	4	3	Amber	To make funding available to purchase a washer disinfector	1	1	Green	DHSW,SDO,DO

# Operational Plan for Health Directorate/Section | 2015-18

			and HTM 01-05 guidelines.								
9	SMO	EMIS	Morbidity and mortality as well as litigations resulting from lack of proper medical records	5	5	Red	Audit the use of EMIS.	1	1	Green	SMO
10	SMO	Public health	Morbidity and mortality due to obesity	5	5	Red	Institute properly funded public health initiatives against obesity. Involve politicians to increase tax on unhealthy foods such as fizzy drinks. Involve school.	2	2	Amber	SMO
11	SMO	PH	Morbidity and mortality due to the lack of clean drinking water.	3	3	Amber	Test for wider substances in water, such as heavy metals. We need to obtain outside expertise to be widened.	2	2	Amber	Public health officer
12	SMO	PH	Morbidity and mortality due to poor control on imported food stuff.	4	3	Amber	CE regulations. Take forward Food and Safety Ordinance changes and stop the use of backyard slaughtering for retail.	1	1	Green	DH
13	SMO	Tele-med	Morbidity and mort due to lack tele-med due to lack of proper internet access	4	4	Red	Part of the New Hospital Plan	1	1	Green	DH
13	Admin Services	AD4	Unable to recruit suitably qualified staff across the various sections	3	3	Amber	Recruitment of locums where necessary  Local succession planning and long-term training	3	2	Yellow	DHSW/DHR/AHSSO
14	Admin Services	AD6	Breakdown of Ambulances resulting in inability to respond to accidents/emergencies	5	4	Red	Ambulances are regularly serviced by Govt Garage. Occasions when only 1 ambulance is running is a high risk particularly when this is the Land Rover Ambulance as the	1	1	Green	DHSW/ACHM

# Operational Plan for Health Directorate/Section | 2015-18

						Red	only other ambulance is not capable of going off road which would result in medical assistance being delayed as staff would have to cover the off road areas on foot to reach patients. Basil Read has assisted by allowing the airport construction site ambulance to assist when they were closest to the scene of accidents. Replacement of both ambulances.				
15	Acute & Community	A1	Injury to patient/staff whilst transferring pt from home to hospital due to inappropriate equipment and environmental factors	5	5	Red	Procure correct equipment Appropriate staff training on use of equipment and manual handling techniques	2	2	Yellow	HNO/Procurement committee
16	Acute & Community	A3	Patient (Baby) mortality/morbidity due to unreliable resuscitative in theatre Possible Litigation	5	5	Red	Transfer resuscitaire from labour ward to theatre Weekly checking of machine when not in use and daily checks when in use. Purchase a new resuscitaire Recruitment of a full time technician/engineer	2	2	Yellow	SMO
17	Acute & Community	A6	Patient mortality/morbidity due to cross infection caused by inadequate sterilisation of surgical equipment Possibility of litigation	5	5	Red	To repair and replace sterilisation machine and wash scopes manually	2	2	Yellow	SMO
18	Acute & Community	A13	Gas management	5	5	Red	Install gas management system. Buy a concentrator. Manufacture oxygen.	2	2	Yellow	SMO

## Operational Plan for Health Directorate/Section 2015-18

19	Acute & Community	C2	Diabetic strategic objectives not met due to diabetic nurse acting in vacant CNO post	4	4	Red	Recruit TC officer to this post	2	2	Yellow	DHSW/ACHM
21	Dental Services	D3	Increased morbidity as a result of lack of digital imaging/x-ray facilities.	3	3	Amber	Installation of recently acquired digital intraoral digital imaging machine, planned purchase of digital OPG machine in 2016	1	1	Green	DHSW, SDO, DO
22	Dental Services	D4	Increased patient morbidity and litigation due to patient overexposure to ionising radiation as a result of not implementing an Ionising Radiation Control Policy.	3	3	Amber	To have x-ray machines serviced and tested as per manufactures instructions and follow IRMER guidelines.	2	1	Yellow	DHSW, SDO, DO, Radiographer
24	Dental Services	D11	Morbidity due to absence of a trained technician to service, repair and test instruments and equipment as per manufactures instructions.	4	4	Red	Recruitment of suitably trained medical technician to service, repair and test all dental equipment and instruments.	1	2	Green	DHSW, HR, SDO,DO,CD
25	Dental Services	D12	Inability for dental chair to accommodate obese patients above 136kg	2	2	Yellow	To make funding available to upgrade one of the existing dental chairs to be able to accommodate patients in excess of 136kg	2	2	Yellow	DSHW, SDO,DO
26	SMO	Hosp	Discomfort of patients due to lack of privacy & confidentiality	5	5	Red		1	1	Green	HN
27	SMO	Rad	Morbidity and mort due to lack of comprehensive diagnostic reporting due to lack of proper internet access	5	5	Red	Obtain better internet bandwidth for hospital. Part of the New Hospital Plan.	1	1	Green	DH

# Operational Plan for Health Directorate/Section 2015-18

28	Admin Services	AD1	Loss of electronic data (medical and other) in the event of back up failure.	4	3	Red	Current Backup Server in place  Back up data tapes held off site by IT Dept. - loss of 1 day's data	3	2	Amber	DHSW/ SMO/AHSSO/ITSM
29	Admin Services	AD3	Outsourcing of Catering Services not proceeding as a result of tenders being over and above the funding available for this activity.	2	1	Yellow	Continue to provide the service within the directorate. Centralise the service at the CCC Kitchen	1	1	Green	DHSW/ ACHM/ AHSSO
30	Admin Services	AD5	Breakdown of vital equipment within the Health Directorate resulting in inability to perform certain procedures.	3	2	Red	Regular maintenance performed and spare parts available where feasible.  Backups of essential equipment.	2	2	Yellow	DHSW/ SMO/ ACHM/ AHSSO
31	Admin Services	AD7	Destruction of Health Department Complex through Rock fall	5	2	Amber	Catch nets are in place on the cliffs above Complex housing the Health Department which provides some protection against damages from minor rock fall but would not likely hold if there was a major rock fall.	4	2	Amber	SHG
32	Admin Services	AD8	Fire outbreak within the Complex which could result in full or partial destruction of buildings including explosion	5	3	Amber	There is a lack of fire detection alarms in the Admin block – being addressed in the redevelopment plans	4	2	Amber	
60	Lab		Patient mortality/morbidity due to inability to contain pathogens and maintain a sterile environment	3	4	Amber	Build 'fit for purpose' Medical Laboratory.	2	2	Yellow	SBS
61	Lab		Patient mortality/morbidity	3	2	Red	Obtain white cell filters or special	2	2	Yellow	SBS

Operational Plan for Health Directorate/Section | **2015-18**

			due to inadequate preparation of blood transfusion products				collection bags with integrated white cell filters to avoid/minimise transfusion reactions				
62	Admin	AD9	Breakdown of telecommunication (i.e. switchboard services) due to current system do not have parts as this system is no longer been produced.	5	5	Red	To purchase and install a new switchboard system for the Directorate (i.e. based in upper Jamestown).	3	4	Amber	ADHSS