Health and Care Jersey – Health and Care Services Board
Part A – Meeting in Public
Minutes

Date: 30 January 2025	**Time:** 9:30am -12:30pm	**Venue:** Main Hall, St Paul's Centre, Dumaresq St, St Helier, Jersey JE2 3RL

Non-Executive Board Members (Voting):		
Carolyn Downs CB	Non-Executive Director	**CD**
Dame Clare Gerada DBE	Non-Executive Director	**CG**
Anthony Hunter OBE	Non-Executive Director	**AH**
Julie Garbutt	Non-Executive Director	**JG**
David Keen	Non-Executive Director	**DK**
Executive Board Members (Voting):		
Tom Walker	Chief Officer HCJ	**TW**
Mr Simon West	(Acting) Medical Director	**SW**
Obi Hasan	Finance Lead – HCJ Change Team	**OH**
Executive Board Members (Non-Voting):		
Jessie Marshall	Chief Nurse	**JM**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Andy Weir	Director of Mental Health, Social Care and Community Services	**AW**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Ian Tegerdine	Director of Workforce	**ITe**
In Attendance:		
Cathy Stone	Nursing / Midwifery Lead – HCJ Change Team	**CS**
Mark Pugh	Medical Lead – HCJ Change Team	**MP**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**

1	**Welcome and Apologies**

CD welcomed all in attendance.

No apologies.

2	**Declarations of Interest**

No declarations.

3	**Minutes of the Previous Meeting**

The minutes of the previous meeting held on 28 November 2024 were agreed as accurate.

4	**Matters Arising and Action Tracker**

ACTION 155: CT advised the Board that informatics will be able to support the required change (based on user feedback) during Q1 2025. Remain **OPEN**.

ACTION 154: TW advised that the relevant policy is clear and all patients transferring to the public waiting lists do so according to clinical priority and then chronologically. The policy will be published for transparency. The policy has been checked for consistency across other healthcare jurisdictions. In conclusion, TW assured that there is a robust policy in place however, there may be cases where patients are seen privately and their clinical priority changes. CD thanked TW and advised that it is important to endure adherence to this policy. Agree **CLOSE**.

5	**Chair's Introductions**

CD discussed several changes. Mr. Simon West (SW) was introduced as the new Medical Director. SW is an orthopaedic surgeon and will continue his clinical practice alongside his new role. He was appointed by the Jersey Appointments Commission, and everyone is delighted that he has accepted the role and started immediately. Congratulations and welcome, Simon.

HCJ is pleased to support the Government of Jersey (GoJ) with the secondment of Dr. Anuschka Muller, Director of Improvement and Innovation, who will be working with the Cabinet Office on a government-wide strategic project. Congratulations, Anuschka.

Meanwhile, Rachel Williams (Director Public Health Delivery) will be working with TW to review the proposed integrated health and care system structures. This work is expected to return to the Board as soon as possible to help the Board understand the different roles within this system.

6	**Chief Officer Report**

Chief Officer Report Summary

TW, Chief Officer, highlighted key points from his report to the Board:

1. **Integration of Health and Care System**: The year began with the formation of Health and Care Jersey, aiming to create a more integrated health and care structure for Jersey. As of January, Public Health and health policy colleagues have joined Health and Care Jersey, with further integration opportunities expected throughout the year.

2. **New Health Care Facilities Program**: The States Assembly approved funding for the new health care facilities (NHF) program in December during the budget debate, marking an important milestone. The procurement process for the main developer is underway, which is crucial for the hospital's construction. Additionally, the planning application has been submitted and will be reviewed by the planning committee in February 2025, with hopes for a positive outcome.

3. **Progress on Assisted Dying**: The States Assembly has voted in principle in favour of assisted dying. The policy team will now draft legislation to implement this in Jersey. This development will have significant implications for health and care providers, including HCJ, and will be revisited later in the year once the assembly's decision is clarified.

4. **Top Priority Areas for Improvement**: The executive team will focus on the following areas during 2025:
    a. **Clinical Standards**: Enhancing clinical standards across the board.
    b. **Patient and Service User Flow**: Improving the flow of patients and service users through the system.
    c. **Budget Management**: Living within the budget allocated by the assembly.
    d. **Workforce**: Addressing long-standing vacancies and strengthening the workforce.
    e. **Off-Island Service Offer**: Rationalising tertiary care arrangements and taking a strategic approach to off-island services.

5. **Inspection by the Jersey Care Commission (JCC)**: This year, the department will prepare for its first inspection by the JCC, a significant milestone for the department and the service. This important piece of work will be revisited by the board later in the year.

ADHD Waiting List Concerns: CG raised concerns about the nearly 1,000 adults on the waiting list for ADHD assessments in Jersey, equating to about 1 in 50 adults. The current waiting time is approximately four years. Recommendations from the quality committee include:

a. **Prioritisation**: Focusing on those most affected by ADHD, such as individuals in prison, pre-sentencing adults, young adults transitioning from childhood ADHD, and those with drug and alcohol use issues.
b. **Impact Assessment**: Evaluating the financial and health impacts of addressing the waiting list by recruiting more staff.
c. **Review of ADHD Diagnosis**: Considering the ongoing review in England regarding the rise in ADHD diagnoses and potential misidentification with anxiety or stress.
d. **Deep Dive into High Diagnosis Rates**: Investigating why Jersey has such a high rate of ADHD diagnoses and involving patients and the public in this review.

e. **Patient Communication**: Finding ways to contact and support patients on the waiting list, including providing self-help materials and managing expectations about their likelihood of being seen unless they are in a priority group.

Tom Walker acknowledged the need to prioritise high-priority patients on the ADHD waiting list, similar to other clinical services. This issue will be further addressed by AW in the performance report.

TH thanked TW for the report and asked what aspects of the report were particularly notable, emphasising the importance of recognising achievements and having a sense of pride in progress. TH also inquired about the five priorities for the executive and what critical or complex issues were on his mind.

TW expressed pride in the dedication of both clinical and non-clinical staff across the services, noting their commitment to delivering high-quality support to patients and service users.

There are opportunities to enhance the flow of patients and service users through the system, from the emergency department (ED) to delayed transfers of care (DTOC). Improving this flow can significantly boost the resilience of acute services.

This year, there will be a particular focus on patient record keeping, which has been a recurring theme in serious incident (SI) reports. Ensuring accurate record keeping is seen as a lead indicator of adherence to good clinical standards.

TW highlighted the need to review and improve off-island tertiary care arrangements. While some relationships with tertiary care providers are highly valued, others are less so. By strategically reviewing these arrangements, there is an opportunity to enhance the quality of off-island care for Islanders.

ACTION: The board requested updates on the work being done on patient flow and off-island service offers at the next meeting in March. Additionally, a report on the digital agenda will be included. Regular updates on the five priorities will feature on the board agenda in addition to regular finance, workforce, and clinical improvement items.

7	**Environmental Sustainability**	**Action**

Ross Barnes (RB), Head of Non-Clinical Support Services and Jon Carter (JC), Head of Estates in attendance and presented a series of slides (addendum to these minutes).

CD thanked RB and JC for their comprehensive presentation and opened the floor for questions. CD asked how the Jersey Care Commission (JCC) might rate HCJ estates and facilities if they were to grade them, even though the JCC is not planning to provide such ratings. CD expressed uncertainty about the status of HCJ facilities and sought RB and JC's perspective.

JC responded by acknowledging that whilst there are some good facilities, there are concerns about areas that are part of the new hospital program for development or disposal, which may be slightly below par. In addition, some of the infrastructure dates back to the 1700s through to modern construction, which poses certain limitations. RB emphasised the need for continuous improvement and highlighted the importance of measuring against JCC standards, also noting that there are opportunities to improve communication and support for staff to adopt greener practices.

The World Health Organisation (WHO) emphasises sustainability not just in terms of reducing carbon emissions, but also improving patient care. RB and his team focus on making facilities more sustainable by reducing the administrative burden on clinicians, allowing them to spend more time with patients. This approach aims to separate clinical and non-clinical tasks effectively with significant progress made in this area, continuing to support clinicians in becoming more sustainable. JC added that community care homes have undergone a trial period, and they are on the right path in terms of their built environment.

CG thanked both RB and JC and shared insights from the NHS in England, highlighting issues like dripping taps wasting water and the significant number of healthcare-related car journeys (circa 20%). CG emphasised the importance of accountability at all levels, including doctors and nurses switching off equipment and using digital tools to communicate with patients. CG inquired if the team would engage clinicians in audits to address wastefulness and other issues.

JC confirmed that they are already addressing these issues and use management tools to optimise engineer routes, reducing carbon footprints. In addition, water usage is managed in older infrastructure and implementation of new technologies to improve efficiency. The estate's compliance team also actively monitors and addresses issues, and there are efforts to promote greener travel options among staff.

The board thanked JC and RB for the presentation and offered their full support to enhance their efforts.

8	Quality and Performance Report Month 12	Action

CT provided a verbal summary of the following key areas for acute services.

1. **Outpatient Services**: Discussion regarding the recovery actions for outpatient services, particularly focusing on key specialties where patients have been waiting too long for routine appointments. However, there is assurance that patients with urgent clinical needs are prioritised and an improvement in outpatient activity across acute services noted. However, some pathways that remain a concern, especially in gastroenterology, where additional capacity is being utilised to improve services.

2. **Inpatient Services**: Inpatient activity impacted by theatre capacity due to ventilation and engineering problems, as well as bed pressures, especially during autumn and December 2024. These issues have affected routine surgeries, but urgent elective procedures are being prioritised. In addition, there is focus on those patients who have had their routine surgeries cancelled multiple times, ensuring they are also prioritised.

3. **Access to Diagnostics**: This is a developing metric for the board, with new modalities added for better oversight. The chief of service for surgery is focusing on managing capacity and demand in this area, making it a priority for 2025.

4. **New to Follow-Up Performance**: The speaker is pleased with the performance in this area, noting a reduction in Did Not Attend (DNA) rates due to actions like text reminders and phone calls to patients.

5. **Elective Utilisation**: This remains a priority, with varying improvements. Consistent improvement in late starts is noted, but further progress is needed.

6. **Emergency Activity**: Winter pressures and a rise in medical admissions, particularly respiratory infections, have impacted patient flow and 12-hour performance. Ensuring appropriate placement for patients requiring isolation has been challenging.

7. **Patient Movement and Safety**: The board has learned a lot about moving patients around the hospital to maintain a safe ED and manage handovers from ambulance services. Efforts to reduce inpatient moves, especially out of hours, have been successful, improving patient safety and experience.

CG expressed gratitude for the hard work and improvements seen in various areas, particularly in reducing the rate of rise in waiting times and improving mental health services, such as memory assessments. Acknowledgement of the challenges faced, including technical issues in radiology, building issues affecting scans, and staffing issues but despite these, there have been significant improvements in dermatology, attributed to leadership and the addition of a new consultant. CG emphasises the need for greater engagement from senior clinicians in innovation, both digital and in patient triaging, to continue improving services.

CT suggested the preparation of an assurance paper for the next Finance and Performance Committee which highlights the progress in reducing the over-52-week cohort of patients and move towards sustainability in key specialties (rather than interim recoveries). The focus is on maintaining sustained improvement in outpatient services and addressing challenges in elective care. As winter pressures ease, the aim is to concentrate on specific specialties to ensure continued progress.

TW thanked CT for the focus on diagnostics and the efforts to improve this area.

AW provided the following verbal summary of the Mental Health and Social Care indicators. Key points include:

1. **Jersey Talking Therapies Initial Assessments and Treatment Wait Times**: While initial assessments are conducted quickly, there are longer wait times for treatment. An 18% rise in referrals last year, particularly in November, has contributed to this issue. The service is exploring ways to manage the increased demand, possibly by reordering the process to balance wait times for assessments and treatments.
2. **Access Targets**: Despite a 28% increase in referrals to mental health services in 2024, the teams have maintained their access targets. Notably, 100% of crisis team referrals in December were seen face-to-face within 4 hours, and 95% of referrals are seen within 10 days. AW highlighted the significant effort of the team in achieving in achieving this.
3. **Waiting Times for Specific Services**: There has been a slight dip in waiting times for memory assessment, and autism services due to changes in ways of working. The memory assessment team is praised for their clinically led work in achieving waiting time targets and AW expressed gratitude for the hard work and dedication of the teams involved.
4. **Adult Social Care Indicators**: New indicators for adult social care will be monitored, with a focus on maintaining high performance levels (see item 9 on this agenda). There has been a decrease in the process indicator for assessments being authorised within three weeks, which returned to 100% compliance in December.

ADHD Waiting Times

The waiting time for ADHD referrals is currently four years, with 924 people on the waiting list (also a cohort of young people waiting to transition from Child and Adolescent Mental Health Services (CAMHS) to adult services. The service is struggling to meet the demand, with clinicians dividing their time between assessing and prescribing. The prescribing list is managed by a limited number of doctors, and drug availability issues exacerbate the problem.

1. **Prioritisation and Support**: The clinical team is developing criteria for prioritising patients on the waiting list. Psychological support and education groups have been introduced for those waiting, and a clinical nurse specialist has been budgeted for to increase capacity.

2. **Shared Care Model**: Discussions are ongoing about a shared care model with the primary care board, which could impact prescribing capacity. However, CG expressed concerns about the appropriateness of GPs prescribing ADHD medications due to their potential risks and urged HCJ / GPs to address this through a different route.

3. **Deep Dive into ADHD Diagnosis**: CG suggested a deep dive into Jersey has such high ADHD diagnosis rates. This would likely need to be commissioned externally to avoid overburdening the current service and conflicts of interest.

4. **Screening and Assessment Process**: The service screens referrals before assessment, which has led to a high positive assessment rate (90-95%). The process includes self-assessment forms and clinical screening to ensure appropriate referrals. CG highlighted the unusual 98% conversion rate from referral to diagnosis for ADHD, suggesting that this indicates a self-diagnostic identity rather than a clear clinical condition.

CG asked if consideration has been given to closing the ADHD waiting list, which currently has nearly 1,000 people, suggesting that the waiting list should only remain open for those meeting specific priority thresholds, such as prisoners pre-sentencing, transitioning young people, and those known to abuse cocaine or amphetamines. This is due to the unmanageable size of the waiting list and the need to send a clear message about prioritisation.

AW responded that the issue of closing the waiting list has been discussed twice before, and many NHS trusts have already closed their waiting lists for non-emergency referrals. Closing the waiting list would help manage the current demand and ensure that resources are focused on those with the most urgent needs. However this is a complex and sensitive issue and closure of the waiting list is as a political decision that needs to be discussed with the Minister.

CD concluded that this is a complex issue which requires very careful consideration and emphasised the importance of further updates at the board.	

9	Social Care Indicators	Action

AW advised the board of the development of new indicators for adult social care, created in collaboration with social workers. The goal is to ensure the indicators covered the responsibilities of the social care team and included outcome-based metrics, not just process indicators. Key performance indicators (KPIs) proposed include:

1. **Significant Restriction of Liberty Assessment**: Metrics related to mental health law and social care.
2. **Effective Flow**: Metrics to understand patient flow in and out of hospitals and whether people stay at home after discharge.
3. **Annual Health Checks and Care Plan Updates**: For people with learning disabilities.
4. **Qualitative Metrics**: Three metrics to be reported quarterly, asking people if the intervention made a difference, particularly in safeguarding. CD raised a concern about how to gather responses from individuals who cannot respond themselves, suggesting that friends and family might respond on their behalf. The team is considering how to best address this, especially in the learning disability service.

Discussion ensued highlighting the importance of balancing the number of indicators and ensuring they focus on the right aspects. Some indicators will provide a comparative basis with the UK, while others are specific to Jersey. The shift towards outcome-based indicators and the emphasis on service user satisfaction were welcomed as they contribute to mental health and quality of life.
CT added that the developing metric on keeping older people at home is crucial. By examining readmission rates, the effectiveness of procedures and pathways within acute care and support ongoing recovery at home can be assessed. This metric will provide detailed insights into performance, especially since a significant portion of readmissions involves individuals over the age of 75. Understanding these details will help drive improvements in other areas as well.

The Board looks forward to seeing the results of these new indicators.

10	Workforce Report Month 12	Action

As the People and Culture Committee reviewed the workforce indicators in-depth, the Board asked ITe for a focus on sickness absence rates.

- **Previous Concerns and Improvements:** ITe reminded the Board that the People and Culture Committee received a paper on sickness in 2024, and significant work has been done since then. Initial concerns about the accuracy of sickness reporting have been addressed, leading to better reporting practices.
- **Data Issues and Solutions:** Problems such as missing data have been identified and seeking to resolve. Efforts are ongoing to ensure managers report sickness accurately, with a noted discrepancy in reporting quality between medical and non-medical staff.
- **Current Sickness Rates:** The current sickness rate is around 6.4%, up from 5.3% previously. Comparisons with other regions show varied rates: Scotland and Wales report above 6%, NHS England around 5%, and the Isle of Man approximately 5%.
- **Benchmarking Challenges:** Benchmarking against other jurisdictions is challenging due to differences in reporting and context.
- **Focus on Well-being:** The primary goal is to understand the root causes of sickness absence and provide well-being support for staff, rather than punitive measures.
- **Long-term and Short-term Sickness:** A review of long-term sickness cases is complete, with increased focus on identifying patterns in short-term sickness. The People and Culture Committee will receive a detailed statistical analysis in their next meeting (February 2025).
- **Data Refinements:** Further refinements of the data are needed to better understand sickness patterns, including average and mode durations of sickness spells.
- **Anxiety and Stress as Major Absence Reasons:** CD noted that anxiety and stress are the third most common reasons for absence, with 761 instances reported. This issue is seen as something that can be directly addressed and positively impacted by the board. There is a

strong call for a concerted effort to reduce anxiety and stress among staff, as it is a significant concern, almost as prevalent as gastrointestinal problems.

Cross-referencing Surveys and Creating a Heat Map:

- **Creating a Heat Map:** The goal is to create a heat map to identify areas within the organisation with higher instances of grievances, vacancies, turnover, disciplinaries, and sickness levels. This will help pinpoint managerial and other issues. The heat map will correlate various data points, including Freedom to Speak Up issues and staff survey results, to provide a clear picture of problem areas. Although the timeline for completing this heat map is uncertain (aiming end Q1 2025), staff are actively working on it, and it remains a priority.

Anxiety and Stress:

- CG emphasised the need to change the narrative around anxiety and stress. The current metric for sickness due to anxiety and stress is seen as part of a broader issue where people feel they need to be 100% well to work. It was highlighted that work can improve mental health and well-being. The goal is not to make everyone happy all the time but to understand and communicate that stress can be beneficial in certain contexts.
- **Managing Emotions and Stress:** Efforts should be made to help individuals manage their own emotions and stress effectively.

Support for Workforce Mental Health:

- **Understanding External Pressures:** TH emphasised the importance of understanding how external pressures impact employees' mental health at work and providing appropriate support.
- **Low Utilisation of Employee Assistance Program:** It was noted that the HCJ workforce has a low uptake of the government-provided Employee Assistance Program (EAP), partly due to HCJ having its own initiatives. One of the targets for the year is to increase access to EAP services, which offer a range of support, including financial and commercial advice. The aim is to integrate these services more effectively within the health sector.

11	BeHeard Survey	Action

The BeHeard Survey, conducted by a third-party company, is distributed across the entire GoJ, including HCJ. HCJ achieved a response rate of circa 30%, which is lower than desired. Improving this response rate is a key target for the year. For comparison, the NHS achieves about 48%, Scotland around 59-60%, and Wales about 20%. Increasing engagement with the survey is crucial to better hear from people.

Despite the low response rate, the survey results revealed some positive news. Overall, more people are happy working within HCJ than are unhappy, and this positive sentiment has increased since the last survey.

Improvements were noted in various domains such as leadership, teamwork, personal growth, well-being, and feeling valued. However, there was a slight decline in how people feel about working in teams, which needs further investigation. The organisation is developing plans to address these issues and aims to drive further improvements. Key themes from the action plan include leadership and management, communication, teamwork, learning from errors, and supporting staff who report issues. The next survey will be conducted soon, and the organisation is committed to continuous improvement.

Additionally, the NHS uses the Friends and Family Test to gauge whether staff would recommend their workplace for care to friends and family. Understanding why staff in HCJ are not as positive as those in other jurisdictions is important. This feedback will be incorporated into the corporate plan. Each care group is also asked to deep dive into their results and develop local plans to address any discrepancies. These plans will be scrutinised during monthly performance reviews from February 2025. The overall corporate plan is expected to be completed by the end of February, alongside the survey results for this year.

The 2025 BeHeard Survey has been brought forward to the summer, rather than the usual autumn schedule, giving less time to make an impact before being resurveyed. This change is likely due to

the GoJ aim to find the best time of year for optimal responses. Additionally, HCJ plans to conduct its own Pulse Survey to check in with staff, potentially using the same structure as the BeHeard Survey. Despite the challenges, there is positive progress, and staff feedback indicates that HCJ is moving in the right direction. The focus remains on reflecting on these positive developments and continuing to improve.

Whilst CD emphasised the importance of recognising significant improvements and celebrating them (particularly in leadership), there are areas of concern, such as the lower recommendation rate for the service compared to the NHS (42% vs. 65%) and confidence in HCJ addressing concerns. CD suggested focusing the Pulse Survey on these issues and using listening events to understand and address staff concerns. The goal is to see real improvements by 2026, despite the current survey's limitations due to a low response rate and differences in survey scoring methods.

TH added that while the overview provides a general picture, it may mask significant differences between service areas. Understanding these differences is crucial for learning and improvement. TH further noted that changes in management can have a substantial impact on staff morale and happiness. The heat map discussed earlier will help identify these differences, and the People Committee will need to address them in an appropriate environment to ensure confidentiality and effectiveness.

12	**Rheumatology Update**	**Action**

Dr Adrian Noon (AN), Clinical Lead and Rachel Williams (RW), Operation Crocus Director (RW) in attendance and provided with a verbal summary (supported by papers).

RW summarised the background to the review. The Royal College of Physicians (RCP) was invited to review the Rheumatology department and the care received by its patients. This review was initiated due to concerns raised by an individual within Health and Community Services (now HCJ).

The RCP provided several recommendations, and significant progress has been made in addressing these recommendations, as well as additional issues identified by the department. The RCP also recommended a clinical audit of all patients on biologic medication. During this audit, concerns arose, leading to an extended review covering all patients in the Rheumatology department. The review is nearly complete, with independent specialist clinicians reviewing various patient groups.

AN provided detailed explanations of the findings and ongoing actions, specifically noting the hard work of all staff involved. Key points,

- Approximately 2,200 patients have undergone some form of review, most of which were face-to-face with the clinical team.
- Harm assessments were conducted for all these patients, and when concerns about validity arose, the assessments were repeated to ensure accuracy.
- So far, 62 Duty of Candour (DoC) letters have been sent out, with a few more expected.
- Thirty-three cases were referred to the Viscount's office. Of these, meetings have been held with the families of 31 deceased patients. This process has been challenging, especially for elderly relatives and young children, necessitating the development of a comprehensive psychological support service, with significant contributions from mental health colleagues and Jersey Talking Therapies.
- There are still about 80 cases left to review among the deceased, and the process of contacting their relatives is ongoing.

The second paper focuses on the future, detailing the action plan initially developed under the guidance of the RCP.

- Significant changes have occurred in the Rheumatology department over the past 18 months, led by its clinicians and supported by a multidisciplinary team. Regular meetings, proper audits, and good clinical governance have been established. The department hopes to receive a review from the NHS's Get It Right First Time (GIRFT) team later this year for external validation of their progress and to identify further areas for improvement. The department has undergone substantial transformation due to hard work and organisational investment, making it almost unrecognisable compared to 18 months ago.

CD thanked AN and RW for the update and reminded the board that it has regularly received updates. CG suggested that this no longer needs to be a standing item on the board agenda, given the extensive discussions held at the Quality, Safety and Improvement (QSI) Committee. The board concluded that significant changes or issues should still be reported to the board via the committee's updates. Routine matters can be managed by the Quality Committee, with proper minuting to ensure the board remains informed. This approach balances the need for oversight with the recognition of the substantial progress already made.	

13	Acute Medicine Improvement Plan	Action
CT presented the Acute Medicine Improvement Plan (MIP), which has been regularly reported to the board and is scrutinised by the QSI Committee. The plan is based on several internal and external reviews, most latterly, an invited review by the Royal College of Physicians (RCP) in 2022. The culmination of these reviews and internal learnings from serious incidents led to 61 recommendations, with 19 specifically from the RCP 2022 review. All recommendations are progressing well, and concerns about the speed of implementation have been addressed. Many remaining recommendations focus on investing in and recruiting to the medical workforce. The workforce model described by the RCP has been resourced as part of the 2025 budget, providing a framework for future recruitment efforts. CS thanked CT for the report and highlighted the synergies with the Maternity Improvement Plan, noting that a lot of work has been done. However, the success of the plan is due to embedded processes and inquired if the 30/60/90-day process is continuing within the MIP – CT confirmed this was the case. TW asked CT about the challenges in filling some of the funded posts, particularly in difficult-to-fill specialties. CT acknowledged that while there have been successes in recruiting for respiratory and general/acute medical posts, frailty remains a significant challenge, and this post is crucial for admission avoidance services. CT mentioned that professional networking and efforts by Dr Matt Doyle, Chief of Service for Medicine, have generated interest in working for Jersey, which could help improve services. In conclusion, whilst there are challenges, there have been positive changes in some areas. SW in agreement and emphasised the importance of selecting the right candidates for Jersey, given its unique and challenging environment. He noted that while there have been many applicants over the past 18 months, it is crucial to ensure they are the right candidates. Current vacancies have sometimes been due to candidates not adapting well. Despite these challenges, there have been recent successes in recruitment. MP highlighted the difficulty of recruiting physicians, noting that 70% of advertised posts on the mainland do not attract a single appointable candidate. CD asked about the status of recommendation 096, which referred to the 2023 job plans. SW confirmed that the 2022-2023 and 2024 job plans were closed down, and the 2025 cycle will open next Monday (.3 February 2025). The aim is to complete the cycle by the beginning of April 2025, with significant effort and resources devoted to this process. Learning events have been organised to help colleagues understand the job planning software and engage with the process. SW expressed his commitment to ensuring the plan is completed on time. ITe acknowledged the progress made and emphasised the importance of starting the 2026 plans at the end of 2025. This effort, led by the Finance Recovery Programme (FRP) aims to eliminate the backlog and move towards prospective planning. Achieving these ambitious targets will place HCJ in a good position by the end of this year. Proper job planning is crucial for greater efficiency and productivity. OH expressed gratitude for the recognition of the FRP team's hard work.		

14	Finance Report Month 12	Action
2024 Year-End Position:		

- The 2024 year-end financial position is a £28m deficit (forecast £28m),
- This indicates an improved understanding and management of financial variations.

Key Points:

- **Anticipation and Risk Management:** The organisation is getting better at anticipating variations and managing risks. This includes holding reserves and taking proactive recovery actions.
- **Movements and Predictions:** While there were some unexpected movements, these were predicted, and reserves were used to manage these effectively.
- **Cost Containment:** Rising costs and pressures were contained within the forecasted £28 million deficit, avoiding a potential increase to £31-32 million.
- **Savings:** Significant savings were achieved, particularly by care groups, contributing positively to the overall financial performance.

FRP Savings and Mitigation:

- The organisation delivered **FRP Savings of £8.95 million** last year, exceeding the planned £5.1 million. This helped mitigate additional cost pressures and contain the deficit.

Maintaining Momentum:

- The focus is on maintaining this momentum despite ongoing pressures.
- Strategies include proactive measures and learning from past experiences.

2025 Budget and Plan:

- The 2025 budget starts with a funding envelope of **£322.2 million**, an increase of £22 million from the previous year.
- The approach involves recognising efficiencies and demographic-related health pressures.
- Prioritising service provision within the allocated budget is key.

Quality Impact Assessments:

- Decisions are made using Quality Impact Assessments (QIAs), considering quality, operational delivery, and financial constraints which helps balance the budget while maintaining service quality.

Efficiency Savings Plan:

- An ambitious Efficiency Savings Plan of **£13.2 million** is set for 2025 and a further £9m for 2026.
- The organisation aims to deliver over **£39 million in savings** over a four-year period, exceeding the initial plan of £25 million.

Challenges and Mitigations:

- Balancing the budget is challenging, but the organisation is prepared to handle variations and pressures.
- The executive team is focused on proactive planning and mitigation strategies.

Accountability and Visibility:

- The budget is balanced but delivering it will be challenging.
- There is a clear mechanism for accountability and visibility, ensuring the organisation can be held to account for its actions.

Specific Risks and Mitigations:

- **Social Care Costs:** High rising costs in social care, demand-led mental health, and tertiary care contracts are major risks carried forward from last year.
- **Infrastructure Investment:** To mitigate these risks, infrastructure investments have been made to improve processes and control cost pressures.
    - **Examples:** Good buying practices and threshold management for care contracts to ensure fair charges and robust challenges to cost pressures.
    - **Team Investment:** £4 million of the £13 million savings depends on the infrastructure teams' ability to deliver and stop additional costs.

Strategic Initiatives:

- **Sustainable Healthcare Funding:** The organisation is actively supporting government initiatives on sustainable healthcare funding.

- **Integrated Health and Care System:** The vision of an Integrated Health and Care system is seen as a positive step towards financial sustainability and improved service delivery.

CT commented on the benefits of understanding of the cost of activity. Nearly 600 more inpatient procedures were performed in 2024 compared to 2023 with the same staff base, reducing waiting lists. Despite significant non-pay pressures, more care was provided, and resource prioritisation is improving.

Future Outlook:

- **Proactive Planning:** The organisation is focused on proactive planning and mitigation strategies to handle inevitable variations and pressures.
- **Accountability:** There is a clear mechanism for accountability and visibility, ensuring the organisation can be held to account for its actions.

Quality Impact Assessment (QIA) Process:

- **Purpose and Methodology:** The QIA process evaluates the impact of proposed changes on quality and operational performance. Established methodologies and forms are used to conduct these assessments.
- **Decision-Making:** When a decision is made to change a service, typically for cost savings or process changes, the QIA asks a series of questions about the impact on quality and operational performance.
- **Responsibility:** The assessments are completed by the care groups involved, not by the finance team. The finance team may identify opportunities for savings, but the care groups evaluate the quality and operational impacts.
- **Questions:** The QIA includes quality-based and operational impact questions, comparing the current baseline with the potential impact of the proposed changes.

TH asked OH to explain the QIA process further and how the board is assured.

- **Involvement:** Clinicians and managers complete the QIA process, which is then reviewed by a quality impact assessment board.
- **Board Composition:** The board includes the medical director, COO, chief nurse, and a finance representative.
- **Decision-Making:** The board reviews and signs off on the QIA. If the assessment fails, the scheme cannot be implemented without mitigation of identified risks.
- **Principle:** The focus is on ensuring that cost-saving measures do not compromise quality. Better quality of care is often aligned with more efficiency.
- **Assurance:** The QIA process ensures a balance between financial impact and quality maintenance. The executive team collectively reviews and makes decisions, ensuring all aspects are considered.

Strategic Focus:

- **Communication:** It's crucial to communicate with the public that cost reductions can lead to better outcomes and processes.
- **Out of Hours Work:** There is a strong focus on early intervention and improving overall health and quality of life to prevent the need for more expensive care.
- **Minister's Vision:** Aligning with the Minister's vision for an integrated health and care system to achieve financial sustainability and improved service delivery.

Referring to discussions as yesterday's QSI Committee, CG advised that the average cost of medicines on the island is double that of the UK, despite a healthier population. A tool called Blue Tech has been introduced to identify appropriate and inappropriate prescribing, potentially saving up to 10-20% of the £20 million prescribing budget.

Following TH's reference to out of hospital work, AW emphasised the redesign and development of services while managing demand and costs. The community services care group has a business plan focused on admission avoidance and reducing unnecessary hospital admissions. Efforts are being made to discharge patients more quickly and provide care at home, aligning with the five priorities for health and community services.

SW talked about the importance of financial leadership and the presence of a finance director within the executive team is crucial for maintaining financial control and governance. This role ensures a

balance between financial management and quality of care. Secondly, the grip and control regarding off-Island Care is encouraging.

CD concluded that the board is working on improving processes and investing in tools like Blue Tech to achieve savings and better outcomes. There is a clear accountability for delivering savings and achieving financial targets which is a collective effort involving the entire team, not just the finance director.

15	Annual Plan 2024	Action

AM advised that the annual planning process involves creating a plan at the beginning of the year and then reviewing the year's performance against this plan at the end. This review includes various aspects, such as finances and quality performance indicators, which have already been covered. Other areas which receive less coverage are,

- **Recommendation Follow Up:** Although this area is not usually highlighted, it is important to note that recommendations are rigorously followed up in the background and included in the annual plan. Recommendations come from the Comptroller and Auditor General, Public Accounts Committee and Scrutiny Panels. 2024 started with **86 recommendations and b**y the end of 2024, the number of open recommendations was reduced to 25. By the end of Q1 2025, anticipating only two open recommendations remaining. Beyond the numbers, this progress reflects a positive message around service improvement.
- **Jersey Care Commission Preparation**: Significant efforts have been made in this area, and updates are included in the report.
- **New Hospital Digital Programs**: Various projects are listed, with some completed and others still ongoing. There has been some reprioritisation of these projects.
- **Quality Account Update**: An update on the quality account will be provided separately, but there is already a preview of achievements in this area.
- **Workforce Culture**: This aspect is usually covered and is noted in the report.

The board noted the annual report against last year's plan, highlighting the progress and achievements.

16	Committee Reports	Action

The board received a summary from each of the committees.

a. **People and Culture:**
The committee spent significant time discussing the BeHeard Survey. Workforce issue also discussed regularly at the Board, including this morning.

b. **Finance and Performance Committee**
Report taken as read.

c. **Quality, Safety, and Improvement Report:**
CG highlighted two areas of concern for the committee,

- **C. difficile Infection**: There is a significant rise in Clostridium difficile (C. difficile) infections, which are antibiotic-resistant and predominantly occur in hospitals. This rise is largely due to inappropriate prescribing of certain antibiotics. The new Blue Tech system will help identify which departments or individuals are prescribing these antibiotics. This monitoring is crucial as C. difficile infections can extend hospital stays and have serious implications for patient health.

- **Prescribing (Private and Public) - Medicinal Cannabis**:
There is a notable increase in the use of medicinal cannabis, particularly in private prescriptions, which impacts the quality of care in other departments, especially mental health. The number of people on medicinal cannabis in the UK is around 0.04%, but on the island, it is significantly higher, estimated to be 150 to 200 times greater. This issue is being addressed by various committees, including those focused on the misuse of drugs.

For clarification, SW explained that whilst the Blueteq system was discussed yesterday, the system demonstrated was a Power BI dashboard has been developed to monitor prescribing patterns, which will help tremendously in managing prescriptions. MP noted a concern about the lack of staff to manage ward-level prescribing, particularly antibiotic pharmacists who can oversee the prescription of antibiotics. The rise in hospital acquired infections (HAIs) is a consequence of this. Recruitment is underway to fill pharmacy vacancies which will allow pharmacists to work clinically on the wards, improving the overall pharmacy service.	

17	**Board Assurance Framework 2024**	**Action**
The Board Assurance Framework has been reviewed, and the agenda has been assessed to ensure all issues are covered. Recent committee meetings in January 2024, deferred from the end of December 2024, have been conducted. The agenda for these meetings are structured to address key controls and assurances for scrutiny. There has been learning from the 2024 process, which was the first iteration. This learning will be incorporated into the 2025 framework. The updated framework for 2025 is aiming for board presentation in March 2025.		

18	**Risk Appetite Statement**	**Action**
TW advised that the risk appetite statement has been updated to reflect the current status, in line with normal risk management practices. A further review will be conducted in the next 12 months to ensure it remains current. CD noted the risk appetite is generally moderate across most areas, with a low appetite for financial risk to avoid overspending. CD thanked TW and the board looks forward to further iterations as risk appetite develops.		

19	**Questions from the Public**	**Action**
The board received a presubmitted questions, **Question 1.** *What measures are in place to stop a consultant in their private clinic prescribing medication to their patients on hospital prescriptions at the expense of the tax payer? The majority of hospital prescriptions are now prescribed using an electronic system. What is in place to prevent a consultant logging into the electronic system remotely and submitting a prescription to the hospital pharmacy?* **Response**: SW responded that the public and private prescribing processes are distinct. The electronic prescribing system is used only for public patients. There is a separate paper-based system for all private prescriptions. This clear demarcation separates the systems to ensure there is no confusion regarding how to prescribe for each pathway. The majority of private scripts are directed to community pharmacies, but some are dispensed by the hospital pharmacy where the drug is only available to order by HCJ. Occasionally a prescriber might make an error and prescribe a private script on the public system. On the rare occasions when this might occur, the prescriber would be reminded of process. Should it become a matter of persistent error, then this would become a matter for professional standards. CD asked SW if there is confidence in the system described and does it stop individuals working the system to their advantage. SW explained that the systems are designed to give clinicians a clear choice. There is no evidence to suggest that clinicians are abusing the system.		

Question: Reflecting on personal experiences, can a deep dive been undertaken so as to understand how many discharge letters are incorrect?

Response: SW responded that this is an area of constant review and errors are noted within discharge letters. SW will be meeting with the COO and Chief Nurse this week to review how discharge letters can be improved both from a quality perspective and timeliness. Ideally, patients should be discharged with the letter and with a digital solution, transferred electronically to the GP on discharge.

CG noted that the review of the role of the community pharmacist within the whole Island system should also lead to improvements in this area, specifically medicines reconciliation.

Question: The perceived lack of gluten free food available throughout the hospital is unacceptable.

Response: Gluten free food is a choice on all patient menus within HCJ. In response to a further question regarding the delay in patient menus, despite positive steps towards using local produce, JM explained that the dietician needed specific software to analyse the nutritional elements of the menus efficiently. This software has now been acquired, and the dietician will soon begin the work, which will expedite the process of reconfiguring the menus for patients.

Question: What is the most recent readmission rate?

Response: The information is available within the board papers; Month 12 position circa 14% with an average of 11%.

Question: Regarding the number of hospital beds, there used to be 240 which has reduced to 150 – how are the –90 accounted for?

Response: CT responded that there are >150 beds open currently, and ward-by-ward detail can be provided at the next meeting.

ACTION: CD suggested that the bed base could be included in the paper regarding patient flow planned for the meeting in March 2025.

Question: C*larification sought about the "general medicine" category, which currently has 55 people on the waiting list with a median waiting time of 96 weeks (almost 2 years). They are unsure what conditions or treatments fall under this category and are asking for more information about the patients on this list.*

Response*: T*he discussion revolves around the "general medicine" category, which includes patients referred by GPs for conditions that don't fit into specific specialties like rheumatology or cardiology. There are 55 people on this list with a median waiting time of 96 weeks. The referrals are made when GPs feel unable to manage the conditions, which might not be urgent but still require further investigation. The referrals are triaged by consultants who determine their priority. The lack of general physicians and the over-specialisation in medicine contribute to the long waiting times.

ACTION: The need for better prioritisation and more detailed information about these patients was acknowledged, and further details will be provided in the next waiting list report.

Question*:* The speaker raises two main concerns. First, they question whether all current consultants are members of their relevant specialist register and if other specialties prescribing biologics undergo the same pharmacy review as rheumatology. Second, they discuss the challenge of effectively using Supporting Professional Activity (SPA) time in consultants' job plans to address pressing clinical priorities. They suggest that the board might consider seeking advice on these issues to ensure SPA time is used efficiently and in line with concerns raised this morning.

Response: SW confirmed that the current rheumatologist is on the specialist register. The Blueteq software, used alongside a biologic pharmacist, interrogates clinicians on their reasons for prescribing biologic agents. This software is not just for cost control but ensures appropriate use across various specialties, including neurology, dermatology, and paediatrics. The Medicines

Optimisation Committee also regularly reviews prescribed medicines to ensure proper use. Thise not on the specialist register will be working under the supervision of those that are. Secondly, regarding job planning, the standard British Medical Association (BMA) allowance for Supporting Professional Activities (SPA) time is 1.5 sessions for revalidation, appraisal, and continuous professional development, with up to 2.5 SPA time allowed historically (specific in Jersey). The speaker emphasises the importance of knowing how SPA time is used to ensure it is valuable and suggests that it might be more beneficial for consultants to see patients if SPA time is not being used effectively. The meeting concludes with no further questions.	

	MEETING CLOSE	**Action**
Date of next meeting: Thursday 27th March 2025		